Regence

REGENCE BRIDGE

Outline of Coverage

For plan effective dates January 1, 2025 - December 31, 2025

Medicare Supplement (Medigap) plans
A, C, F, G, K and N

Regence BlueCross BlueShield of Oregon

REG-OR-36344-24/08

Table of contents

Regence BlueCross BlueShield of Oregon

Benefit chart of Medicare Supplement plans sold on or after June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in our state. The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below. See Outlines of Coverage sections for details about all plans.

BASIC BENEFITS

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end

Medical expenses: Part B coinsurance (generally 20% of the Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments

Blood: First three pints of blood each year

Hospice: Part A coinsurance

A	B	C	D	F/F*	G
Basic, including 100% Part B coinsurance					
		Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible
		Part B deductible		Part B deductible	
				Part B excess charges (100%)	Part B excess charges (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency

Plan F also has an option called a high deductible plan F.* ***Regence BlueCross BlueShield of Oregon does not offer a high deductible Plan F**. The high deductible plan pays the same benefits as Plan F after one has paid a $2,870 calendar year deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.*

Regence BlueCross BlueShield of Oregon

Outline of Medicare Supplement (Medigap) coverage – Page 2

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% skilled nursing facility coinsurance	75% skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit $7,220; paid at 100% after limit reached	Out-of-pocket limit $3,610; paid at 100% after limit reached		

Premium information—Female non-smoker, includes all discounts

Rates effective January 1, 2025

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date. You may receive a monthly premium discount of $45 if you qualify for our household discount. You qualify if **(1)** you reside with a spouse or domestic partner of any age, or **(2)** you currently reside with at least one, but no more than three, other adults who are age 60 or older. The household discount will be removed if the other person no longer resides with you, other than in the case of his or her death.

Female monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$125	$211	$213	$169	$80	$135
65	$125	$211	$213	$169	$80	$135
66	$125	$226	$228	$169	$80	$135
67	$125	$241	$242	$169	$80	$135
68	$133	$257	$258	$179	$86	$144
69	$141	$268	$270	$190	$92	$152
70	$149	$284	$286	$200	$98	$161
71	$157	$296	$297	$210	$104	$170
72	$165	$311	$313	$221	$110	$178
73	$174	$319	$321	$231	$116	$187
74	$182	$332	$334	$241	$122	$196
75	$190	$345	$346	$251	$128	$204
76	$198	$355	$357	$262	$134	$213
77	$206	$371	$374	$272	$140	$222
78	$214	$379	$380	$282	$146	$230
79	$222	$383	$387	$292	$152	$239
80	$231	$393	$395	$303	$158	$247
81	$239	$401	$403	$313	$164	$256
82	$247	$408	$411	$323	$170	$265
83	$255	$418	$420	$334	$176	$273
84	$263	$425	$427	$344	$182	$282
85	$271	$428	$430	$354	$188	$291
86	$279	$428	$430	$364	$194	$299
87	$288	$428	$430	$375	$200	$308
88	$296	$428	$430	$385	$206	$317
89	$304	$428	$430	$395	$212	$325
90+	$312	$428	$430	$406	$218	$334

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female non-smoker, EFT discount

Rates effective January 1, 2025

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Female monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$170	$256	$258	$214	$125	$180
65	$170	$256	$258	$214	$125	$180
66	$170	$271	$273	$214	$125	$180
67	$170	$286	$287	$214	$125	$180
68	$178	$302	$303	$224	$131	$189
69	$186	$313	$315	$235	$137	$197
70	$194	$329	$331	$245	$143	$206
71	$202	$341	$342	$255	$149	$215
72	$210	$356	$358	$266	$155	$223
73	$219	$364	$366	$276	$161	$232
74	$227	$377	$379	$286	$167	$241
75	$235	$390	$391	$296	$173	$249
76	$243	$400	$402	$307	$179	$258
77	$251	$416	$419	$317	$185	$267
78	$259	$424	$425	$327	$191	$275
79	$267	$428	$432	$337	$197	$284
80	$276	$438	$440	$348	$203	$292
81	$284	$446	$448	$358	$209	$301
82	$292	$453	$456	$368	$215	$310
83	$300	$463	$465	$379	$221	$318
84	$308	$470	$472	$389	$227	$327
85	$316	$473	$475	$399	$233	$336
86	$324	$473	$475	$409	$239	$344
87	$333	$473	$475	$420	$245	$353
88	$341	$473	$475	$430	$251	$362
89	$349	$473	$475	$440	$257	$370
90+	$357	$473	$475	$451	$263	$379

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female smoker, includes all discounts

Rates effective January 1, 2025

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date. You may receive a monthly premium discount of $45 if you qualify for our household discount. You qualify if **(1)** you reside with a spouse or domestic partner of any age, or **(2)** you currently reside with at least one, but no more than three, other adults who are age 60 or older. The household discount will be removed if the other person no longer resides with you, other than in the case of his or her death.

Female monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$155	$256	$259	$207	$102	$167
65	$155	$256	$259	$207	$102	$167
66	$155	$274	$276	$207	$102	$167
67	$155	$291	$293	$207	$102	$167
68	$164	$310	$311	$219	$109	$177
69	$174	$323	$326	$231	$116	$187
70	$183	$342	$344	$243	$123	$197
71	$193	$356	$357	$255	$130	$208
72	$202	$374	$376	$268	$137	$217
73	$213	$383	$386	$280	$144	$228
74	$222	$399	$401	$291	$151	$239
75	$231	$414	$415	$303	$159	$248
76	$241	$426	$428	$316	$166	$259
77	$250	$444	$448	$328	$173	$269
78	$260	$454	$455	$340	$180	$279
79	$269	$459	$463	$351	$187	$289
80	$280	$470	$473	$364	$194	$299
81	$289	$480	$482	$376	$201	$309
82	$299	$488	$491	$388	$208	$320
83	$308	$500	$502	$401	$215	$329
84	$317	$508	$510	$413	$222	$340
85	$327	$511	$514	$424	$229	$350
86	$336	$511	$514	$436	$236	$360
87	$347	$511	$514	$449	$243	$370
88	$356	$511	$514	$461	$250	$381
89	$366	$511	$514	$473	$257	$390
90+	$375	$511	$514	$486	$264	$401

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female smoker, EFT discount

Rates effective January 1, 2025

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Female monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$200	$301	$304	$252	$147	$212
65	$200	$301	$304	$252	$147	$212
66	$200	$319	$321	$252	$147	$212
67	$200	$336	$338	$252	$147	$212
68	$209	$355	$356	$264	$154	$222
69	$219	$368	$371	$276	$161	$232
70	$228	$387	$389	$288	$168	$242
71	$238	$401	$402	$300	$175	$253
72	$247	$419	$421	$313	$182	$262
73	$258	$428	$431	$325	$189	$273
74	$267	$444	$446	$336	$196	$284
75	$276	$459	$460	$348	$204	$293
76	$286	$471	$473	$361	$211	$304
77	$295	$489	$493	$373	$218	$314
78	$305	$499	$500	$385	$225	$324
79	$314	$504	$508	$396	$232	$334
80	$325	$515	$518	$409	$239	$344
81	$334	$525	$527	$421	$246	$354
82	$344	$533	$536	$433	$253	$365
83	$353	$545	$547	$446	$260	$374
84	$362	$553	$555	$458	$267	$385
85	$372	$556	$559	$469	$274	$395
86	$381	$556	$559	$481	$281	$405
87	$392	$556	$559	$494	$288	$415
88	$401	$556	$559	$506	$295	$426
89	$411	$556	$559	$518	$302	$435
90+	$420	$556	$559	$531	$309	$446

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male non-smoker, includes all discounts

Rates effective January 1, 2025

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

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Male monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$141	$211	$213	$189	$92	$152
65	$141	$211	$213	$189	$92	$152
66	$141	$226	$228	$189	$92	$152
67	$141	$241	$242	$189	$92	$152
68	$150	$257	$258	$201	$98	$162
69	$158	$268	$270	$212	$105	$171
70	$167	$284	$286	$223	$111	$180
71	$176	$296	$297	$234	$118	$190
72	$185	$311	$313	$246	$124	$199
73	$194	$319	$321	$257	$131	$209
74	$203	$332	$334	$268	$138	$218
75	$212	$345	$346	$279	$144	$228
76	$221	$355	$357	$291	$151	$237
77	$230	$371	$374	$302	$157	$247
78	$239	$379	$380	$313	$164	$256
79	$248	$383	$387	$324	$170	$266
80	$257	$393	$395	$336	$177	$275
81	$265	$401	$403	$347	$184	$284
82	$274	$408	$411	$358	$190	$294
83	$283	$418	$420	$369	$197	$303
84	$292	$425	$427	$381	$203	$313
85	$301	$428	$430	$392	$210	$322
86	$310	$428	$430	$403	$216	$332
87	$319	$428	$430	$414	$223	$341
88	$328	$428	$430	$425	$229	$351
89	$337	$428	$430	$437	$236	$360
90+	$346	$428	$430	$448	$243	$370

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male non-smoker, EFT discount

Rates effective January 1, 2025

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date.

Male monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$186	$256	$258	$234	$137	$197
65	$186	$256	$258	$234	$137	$197
66	$186	$271	$273	$234	$137	$197
67	$186	$286	$287	$234	$137	$197
68	$195	$302	$303	$246	$143	$207
69	$203	$313	$315	$257	$150	$216
70	$212	$329	$331	$268	$156	$225
71	$221	$341	$342	$279	$163	$235
72	$230	$356	$358	$291	$169	$244
73	$239	$364	$366	$302	$176	$254
74	$248	$377	$379	$313	$183	$263
75	$257	$390	$391	$324	$189	$273
76	$266	$400	$402	$336	$196	$282
77	$275	$416	$419	$347	$202	$292
78	$284	$424	$425	$358	$209	$301
79	$293	$428	$432	$369	$215	$311
80	$302	$438	$440	$381	$222	$320
81	$310	$446	$448	$392	$229	$329
82	$319	$453	$456	$403	$235	$339
83	$328	$463	$465	$414	$242	$348
84	$337	$470	$472	$426	$248	$358
85	$346	$473	$475	$437	$255	$367
86	$355	$473	$475	$448	$261	$377
87	$364	$473	$475	$459	$268	$386
88	$373	$473	$475	$470	$274	$396
89	$382	$473	$475	$482	$281	$405
90+	$391	$473	$475	$493	$288	$415

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male smoker, includes all discounts

Rates effective January 1, 2025

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Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date. You may receive a monthly premium discount of $45 if you qualify for our household discount. You qualify if **(1)** you reside with a spouse or domestic partner of any age, or **(2)** you currently reside with at least one, but no more than three, other adults who are age 60 or older. The household discount will be removed if the other person no longer resides with you, other than in the case of his or her death.

Male monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$174	$256	$259	$230	$116	$187
65	$174	$256	$259	$230	$116	$187
66	$174	$274	$276	$230	$116	$187
67	$174	$291	$293	$230	$116	$187
68	$184	$310	$311	$244	$123	$199
69	$194	$323	$326	$257	$131	$209
70	$204	$342	$344	$270	$139	$220
71	$215	$356	$357	$283	$147	$231
72	$226	$374	$376	$297	$154	$242
73	$236	$383	$386	$310	$162	$254
74	$247	$399	$401	$323	$170	$264
75	$257	$414	$415	$336	$177	$276
76	$268	$426	$428	$350	$186	$287
77	$279	$444	$448	$363	$193	$299
78	$289	$454	$455	$376	$201	$309
79	$300	$459	$463	$389	$208	$321
80	$310	$470	$473	$403	$216	$331
81	$320	$480	$482	$416	$224	$342
82	$330	$488	$491	$429	$231	$354
83	$341	$500	$502	$442	$240	$364
84	$351	$508	$510	$456	$247	$376
85	$362	$511	$514	$469	$255	$387
86	$373	$511	$514	$482	$262	$399
87	$383	$511	$514	$495	$270	$409
88	$394	$511	$514	$508	$277	$421
89	$404	$511	$514	$522	$286	$431
90+	$415	$511	$514	$535	$294	$443

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male smoker, EFT discount

Rates effective January 1, 2025

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date.

Male monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$219	$301	$304	$275	$161	$232
65	$219	$301	$304	$275	$161	$232
66	$219	$319	$321	$275	$161	$232
67	$219	$336	$338	$275	$161	$232
68	$229	$355	$356	$289	$168	$244
69	$239	$368	$371	$302	$176	$254
70	$249	$387	$389	$315	$184	$265
71	$260	$401	$402	$328	$192	$276
72	$271	$419	$421	$342	$199	$287
73	$281	$428	$431	$355	$207	$299
74	$292	$444	$446	$368	$215	$309
75	$302	$459	$460	$381	$222	$321
76	$313	$471	$473	$395	$231	$332
77	$324	$489	$493	$408	$238	$344
78	$334	$499	$500	$421	$246	$354
79	$345	$504	$508	$434	$253	$366
80	$355	$515	$518	$448	$261	$376
81	$365	$525	$527	$461	$269	$387
82	$375	$533	$536	$474	$276	$399
83	$386	$545	$547	$487	$285	$409
84	$396	$553	$555	$501	$292	$421
85	$407	$556	$559	$514	$300	$432
86	$418	$556	$559	$527	$307	$444
87	$428	$556	$559	$540	$315	$454
88	$439	$556	$559	$553	$322	$466
89	$449	$556	$559	$567	$331	$476
90+	$460	$556	$559	$580	$339	$488

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Disclosures

Use this outline to compare benefits and premiums among policies. **This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2020.**

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

Regence
P.O. Box 1106
Lewiston, ID 83501

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments less any claims paid.

Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details. Neither Regence BlueCross BlueShield of Oregon nor its producers are connected with Medicare.

Complete answers are very important

When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Regence BlueCross BlueShield of Oregon

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and high deductible F. **Note:** A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G*	K	L	M	N	C	F*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply***	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility Coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025**					$7,220**	$3,610**				

Plans F and G also have a high deductible option which require first paying a plan deductible of $2,870 before the plan begins to pay.* ***Regence BlueCross BlueShield of Oregon does not offer a high deductible Plan F or G**. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.*

***Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.*

****Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.*

Medicare Supplement Plan A

Medicare (Part A) – hospital services – per benefit period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay
Hospitalization*—Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care*—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

******NOTICE:*** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan A (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Medicare Supplement Plan C

Medicare (Part A) – hospital services – per benefit period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay
Hospitalization*—Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care*—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan C (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare **Foreign travel—**Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare Supplement Plan F

Medicare (Part A) – hospital services – per benefit period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay
Hospitalization*—Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care*—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

******NOTICE:*** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan F (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts***	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare			
Foreign travel—Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare Supplement Plan G

Medicare (Part A) – hospital services – per benefit period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay
Hospitalization*—Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care*—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

******NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan G (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare			
Foreign travel—Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare Supplement Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7,220 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess charges") and you will be responsible for paying this difference between the amount charged by your provider and the amount paid by Medicare for the items or service.**

Medicare (Part A) – hospital services – per benefit period

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay*
Hospitalization—Semi-private room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $1,676	$838 (50% of Part A deductible)	$838 (50% of Part A deductible)♦
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital**			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $104.75 a day (50% of Part A coinsurance)	Up to $104.75 a day (50% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for out-patient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan K (cont.)

Medicare (Part B) – medical services – per calendar year

****Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay*
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts****	$0	$0	$257 (Part B deductible)****◆
Preventive benefits for Medicare-covered services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $7,220)*
Blood			
First 3 pints	$0	50%	50%◆
Next $257 of Medicare-approved amounts****	$0	$0	$257 (Part B deductible)****◆
Remainder of Medicare-approved amounts	80%	Generally 10%	Generally 10%◆
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts****	$0	$0	$257 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	10%	10% ◆

This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $7,220 per year.* ***However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "excess charges") and you will be responsible for paying the difference between the amount charged by your provider and the amount paid by Medicare for the item or service.* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*

Medicare Supplement Plan N

Medicare (Part A) – hospital services – per benefit period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare pays	Plan pays	You pay
Hospitalization*—Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care*—You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

******NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

Plan N (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare pays	Plan pays	You pay
Medical expenses—in or out of hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copay of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copay of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0
Parts A & B home health care—Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan N (cont.)

Services	Medicare pays	Plan pays	You pay
Other benefits—not covered by Medicare **Foreign travel**—Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

Notes

For more information

Call us at **1-844-REGENCE** (1-844-734-3623) (TTY: 711).
9 a.m. to 5 p.m., Monday through Friday.
Or contact your local insurance producer or agent.

regence.com/medicare

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