LIFEWISE
HEALTH PLAN OF OREGON

Outline of Medicare Supplement Coverage
Cover Page: Benefit Plans A, C, F and I

Medicare Supplement coverage can be sold in ten standard plans. This chart shows the benefits included in each plan. All insurance carriers who offer Medicare Supplement plans are required to offer Plan A. Some plans may not be available in your state. LifeWise offers Plans A, C, F and I (see shaded columns below).

Basic Benefits included in all plans:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (20% of Medicare-approved expenses).
- **Blood:** First three pints of blood each year.

Plan A	Plan B	Plan C	Plan D	Plan E	F	F*	Plan G	Plan H	Plan I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care						Preventive Care	

*Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $2,000 deductible. Benefits from the High Deductible Plans F and J will not begin until the out-of-pocket expenses exceed $2,000. 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.

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Basic Benefits for Plans K and L include the same services as Plans A - J (except they don't cover the first three pints of blood) but, cost-sharing for the basic benefits is at different levels.

	Plan K**	Plan L**
Basic Benefits	100% Of Part A Hospitalization Coinsurance Plus Coverage For 365 Days After Medicare Benefits End 50% Other Part A Coinsurance, Including Hospice 50% Part B Coinsurance 100% Coinsurance For Part B Preventive Services	100% Of Part A Hospitalization Coinsurance Plus Coverage For 365 Days After Medicare Benefits End 75% Other Part A Coinsurance, Including Hospice 75% Part B Coinsurance 100% Coinsurance For Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Coinsurance	75% Skilled Nursing Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care Not Covered By Medicare		
	$4,620 Out-of-Pocket Annual Limit***	$2,310 Out-of-Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J.
Once you reach the annual limit, the plan pays 100% of Medicare eligible expenses for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges."
You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

PREMIUM AND PAYMENT INFORMATION

Rates effective January 1, 2009

We can only raise your premium if we raise the premium for all policies like yours in this state. In each year, we base your premium on your age on January 1. For instance, if you are already age 70 on January 1, 2009, we will charge you the rate for policyholders who are age 70-74. If, on January 1, 2009, you have not turned 70 yet, we will charge you the rate for policyholders who are age 65-69.

	MONTHLY RATE PER PERSON			
Age	**1/1/2009**	**Age 65-69**	**Age 70-74**	**Age 75+**
	Plan A	$124.00	$173.00	$203.00
	Plan C	$142.00	$199.00	$232.00
	Plan F	$148.00	$187.00	$220.00
	Plan I	$221.00	$300.00	$350.00

PAYMENT OPTIONS

- AutoPay, LifeWise's monthly bank draft program

OR

- Monthly payment by check and payment coupon

DISCLOSURES

Use this outline to compare benefits and premiums among plans. The information contained in this Outline of Coverage is approved for accuracy by the Insurance Division of the Department of Consumer and Business Services.

READ YOUR CONTRACT 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.

FOR NEW APPLICANTS

RIGHT TO RETURN POLICY

If you find you are not satisfied with your policy, you may return it to P.O. Box 7709, Bend, OR 97708. If you send the policy back to us within thirty days of your original receipt of the policy, we will treat the policy as if it had never been issued and return your initial payment.

POLICY REPLACEMENT

If you are replacing another health insurance policy, *do not* cancel your existing policy 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.
- Neither LifeWise nor its agents are connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. LifeWise 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.

LIFEWISE HEALTH PLAN OF OREGON

P.O. BOX 7709 • BEND, OR 97708-7709

1-800-290-1278

FAX (541) 318-2310

Outline of Coverage - Plan A

MEDICARE (PART A) - HOSPITAL SERVICES PER BENEFIT PERIOD*	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION *Semi-private room and board, general nursing and miscellaneous services and supplies* First 60 days	All but $1,068	$0	$1,068 (Part A deductible)
61st through 90th day	All but $267 a day	$267 a day	$0
91st day and after: • While using 60 lifetime reserve days (which you may use only once)	All but $534 a day	$534 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 enter a Medicare-approved facility within 30 days after leaving the hospital* First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $133.50 a day	$0	Up to $133.50 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 *Available as long as your doctor certifies you are terminally ill and elect to receive these services*	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

* **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.**

Outline of Coverage - Plan A (CONTINUED)

MEDICARE (PART B) - MEDICAL SERVICES PER CALENDAR YEAR	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES - *In or out of the 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, durable medical equipment.* First $135 of Medicare approved amounts **	$0	$0	$135 (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 $135 of Medicare approved amounts **	$0	$0	$135 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES *Blood tests for diagnostic services*	100%	$0	$0
(PARTS A & B)	**MEDICARE PAYS**	**PLAN A PAYS**	**YOU PAY**
HOME HEALTH CARE - *Medicare approved services* Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $135 of Medicare approved amounts **	$0	$0	$135 (Part B deductible)
• Remainder of Medicare approved amounts	80%	20%	$0

** **Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with two asterisks), your Part B deductible will have been met for the calendar year.**

Outline of Coverage - Plan C

MEDICARE (PART A) - HOSPITAL SERVICES PER BENEFIT PERIOD*	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION *Semi-private room and board, general nursing and miscellaneous services and supplies* First 60 days	All but $1,068	$1,068 (Part A deductible)	$0
61st through 90th day	All but $267 a day	$267 a day	$0
91st day and after: • While using 60 lifetime reserve days (which you may use only once)	All but $534 a day	$534 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 enter a Medicare-approved facility within 30 days after leaving the hospital* First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $133.50 a day	Up to $133.50 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 *Available as long as your doctor certifies you are terminally ill and elect to receive these services*	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

* **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.**

Outline of Coverage - Plan C (CONTINUED)

MEDICARE (PART B) - MEDICAL SERVICES PER CALENDAR YEAR	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES - *In or out of the 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, durable medical equipment.* First $135 of Medicare approved amounts **	$0	$135 (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 $135 of Medicare approved amounts **	$0	$135 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - *Blood tests for diagnostic services*	100%	$0	$0
(PARTS A & B)	**MEDICARE PAYS**	**PLAN C PAYS**	**YOU PAY**
HOME HEALTH CARE - *Medicare approved services* Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $135 of Medicare approved amounts **	$0	$135 (Part B deductible)	$0
• Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS - NOT COVERED BY MEDICARE	**MEDICARE PAYS**	**PLAN C PAYS**	**YOU PAY**
FOREIGN TRAVEL - *Not covered by Medicare* *Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA* First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** **Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with two asterisks), your Part B deductible will have been met for the calendar year.**

Outline of Coverage - Plan F

MEDICARE (PART A) - HOSPITAL SERVICES PER BENEFIT PERIOD*	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION *Semi-private room and board, general nursing and miscellaneous services and supplies* First 60 days	All but $1,068	$1,068 (Part A deductible)	$0
61st through 90th day	All but $267 a day	$267 a day	$0
91st day and after: • While using 60 lifetime reserve days (which you may use only once)	All but $534 a day	$534 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 enter a Medicare-approved facility within 30 days after leaving the hospital* First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $133.50 a day	Up to $133.50 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 *Available as long as your doctor certifies you are terminally ill and elect to receive these services*	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

*** 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.**

Outline of Coverage - Plan F (CONTINUED)

MEDICARE (PART B) - MEDICAL SERVICES PER CALENDAR YEAR	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES - *In or out of the 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, durable medical equipment.* First $135 of Medicare approved amounts **	$0	$135 (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 $135 of Medicare approved amounts **	$0	$135 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - *Blood tests for diagnostic services*	100%	$0	$0
(PARTS A & B)	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
HOME HEALTH CARE - *Medicare approved services* Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $135 of Medicare approved amounts **	$0	$135 (Part B deductible)	$0
• Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS - NOT COVERED BY MEDICARE	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
FOREIGN TRAVEL - *Not covered by Medicare* *Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA* First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** **Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with two asterisks), your Part B deductible will have been met for the calendar year.**

Outline of Coverage - Plan I

MEDICARE (PART A) - HOSPITAL SERVICES PER BENEFIT PERIOD*	MEDICARE PAYS	PLAN I PAYS	YOU PAY
HOSPITALIZATION *Semi-private room and board, general nursing and miscellaneous services and supplies* First 60 days	All but $1,068	$1,068 (Part A deductible)	$0
61st through 90th day	All but $267 a day	$267 a day	$0
91st day and after: • While using 60 lifetime reserve days (which you may use only once)	All but $534 a day	$534 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 enter a Medicare-approved facility within 30 days after leaving the hospital* First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $133.50 a day	Up to $133.50 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 *Available as long as your doctor certifies you are terminally ill and elect to receive these services*	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

*** 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.**

Outline of Coverage - Plan I (CONTINUED)

MEDICARE (PART B) - MEDICAL SERVICES PER CALENDAR YEAR	MEDICARE PAYS	PLAN I PAYS	YOU PAY
MEDICAL EXPENSES - *In or out of the 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, durable medical equipment.* First $135 of Medicare approved amounts **	$0	$0	$135 (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 $135 of Medicare approved amounts **	$0	$0	$135 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - *Blood tests for diagnostic services*	100%	$0	$0
(PARTS A & B)	**MEDICARE PAYS**	**PLAN I PAYS**	**YOU PAY**
HOME HEALTH CARE - *Medicare approved services* Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $135 of Medicare approved amounts **	$0	$0	$135 (Part B deductible)
• Remainder of Medicare approved amounts	80%	20%	$0
AT HOME RECOVERY SERVICES - *Not covered by Medicare* *Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan* Benefit for each visit Number of visits covered (must be received within 8 weeks of last Medicare approved visit): Up to the number of Medicare approved visits, not to exceed 7 each week. Calendar year maximum: $1,600	$0	Actual charges to $40 a visit	Balance

** **Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with two asterisks), your Part B deductible will have been met for the calendar year.**

Outline of Coverage - Plan I (CONTINUED)

OTHER BENEFITS - NOT COVERED BY MEDICARE	MEDICARE PAYS	PLAN I PAYS	YOU PAY
FOREIGN TRAVEL - *Not covered by Medicare* *Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA* First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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