

Regence MedAdvantage + Rx Enhanced (PPO)  
Regence MedAdvantage + Rx Classic (PPO)  
Regence MedAdvantage (PPO)

## 2011 Summary of Benefits

Regence BlueCross BlueShield of Oregon  
is an Independent Licensee of the  
Blue Cross and Blue Shield Association

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# Section I

## Introduction to Summary of Benefits

Thank you for your interest in Regence MedAdvantage (PPO). Our plan is offered by Regence BlueCross BlueShield of Oregon, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover, or list every limitation or exclusion. To get a complete list of our benefits, please call Regence MedAdvantage (PPO) and ask for the "Evidence of Coverage."

### You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare plan. Another option is a Medicare health plan, like Regence MedAdvantage (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may be able to join or leave a plan only at certain times. Please call Regence MedAdvantage (PPO) at the number listed at the end of this introduction or 1-800-MEDICARE [1 (800) 633-4227] for more information. TTY/TDD users should call 1 (877) 486-2048. You can call this number 24 hours a day, 7 days a week.

## How can I compare my options?

You can compare Regence MedAdvantage (PPO) and the Original Medicare plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare plan covers.

Our members receive all of the benefits that the Original Medicare plan offers. We also offer more benefits, which may change from year to year.

## Where is Regence MedAdvantage (PPO) available?

The service area for this plan includes: Benton, Clackamas, Clatsop, Columbia, Coos, Curry, Douglas, Hood River, Jackson, Josephine, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill counties in Oregon and Clark County in Washington. You must live in one of these areas to join the plan.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

## Who is eligible to join Regence MedAdvantage (PPO)?

You can join Regence MedAdvantage (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However individuals with End Stage Renal Disease are generally not eligible to enroll in Regence MedAdvantage (PPO) unless they are members of our organization and have been since their dialysis began.

## Can I choose my doctors?

Regence MedAdvantage (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at [www.regence.com/medicare](http://www.regence.com/medicare). Our customer service number is listed at the end of this introduction.

## What happens if I go to a doctor who's not in your network?

You can go to doctors, specialists, or hospitals in or out-of-network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out-of-network. For more information, please call the customer service number at the end of this introduction.

## Does my plan cover Medicare Part B or Part D drugs?

Regence MedAdvantage + Rx Enhanced (PPO) and Regence MedAdvantage + Rx Classic (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Regence MedAdvantage (PPO) does cover Medicare Part B prescription drugs.

Regence MedAdvantage (PPO) does NOT cover Medicare Part D prescription drugs.

## Where can I get my prescriptions if I join this plan?

Regence MedAdvantage + Rx Enhanced (PPO) and Regence MedAdvantage + Rx Classic (PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.regence.com/medicare](http://www.regence.com/medicare). Our customer service number is listed at the end of this introduction.

## What is a prescription drug formulary?

Regence MedAdvantage + Rx Enhanced (PPO) and Regence MedAdvantage + Rx Classic (PPO) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.regence.com/medicare](http://www.regence.com/medicare).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## How can I get extra help with my drug plan costs or get extra help with other Medicare costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1 (800) MEDICARE [1-800-633-4227].  
TTY/TDD users should call 1 (877) 486-2048, 24 hours a day/7 days a week and see [www.medicare.gov](http://www.medicare.gov) "Programs for People with Limited Income and Resources" in the publication *Medicare & You*.
- The Social Security Administration at 1 (800) 772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1 (800) 325-0778 or
- Your State Medicaid Office.

## What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Regence MedAdvantage + Rx Enhanced (PPO), Regence MedAdvantage + Rx Classic (PPO) and Regence MedAdvantage (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Regence MedAdvantage + Rx Enhanced (PPO) and Regence MedAdvantage + Rx Classic (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

## What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Regence MedAdvantage (PPO) for more details.

## What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Regence MedAdvantage (PPO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

## Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

## Please call Regence BlueCross BlueShield of Oregon for more information about Regence MedAdvantage (PPO).

Visit us at [www.regence.com/medicare](http://www.regence.com/medicare) or call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. to 8 p.m. Pacific

Current members should call toll-free 1 (800) 541-8981.

[TTY/TDD users should call 711]

Prospective members should call 1-888-REGENCE (1-888-734-3623) for questions related to the Medicare Advantage program.

[TTY/TDD users should call 711]

Current members should call 1 (800) 541-8981 for questions related to the Medicare Part D Prescription Drug program.

[TTY/TDD users should call 711]

Prospective members should call 1-888-REGENCE (1-888-734-3623) for questions related to the Medicare Part D Prescription Drug program.

[TTY/TDD users should call 711]

For more information about Medicare, please call Medicare at 1-800-Medicare (1-800-633-4227).

TTY users should call 1 (877) 486-2048. You can call 24 hours a day, 7 days a week. Or visit [www.medicare.gov](http://www.medicare.gov) on the Web.

This document may be available in a different format or language. For additional information, call Customer Service at the number listed above.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Regence BlueCross BlueShield of Oregon for details.

## Section II – Summary of Benefits

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>Important Information</b>		
<p><b>1 - Premium and Other Important Information</b></p>	<p>In 2010 the monthly Part B Premium was \$96.40 and may change for 2011 and the yearly Part B deductible amount was \$155 and may change for 2011.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p><b>General</b> Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (\$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1 (877) 486-2048. You may also call Social Security at 1 (800) 772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>General</b> \$127 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>General</b> Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1 (800) MEDICARE (1-800-633-4227). TTY users should call 1 (877) 486-2048. You may also call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p><b>In-Network</b> \$2,500 out-of-pocket limit. All plan services included.</p> <p><b>In and Out-of-Network</b> \$2,500 out of pocket limit. All plan services included.</p>
<p><b>2 - Doctor and Hospital Choice</b></p> <p>(For more information, see Emergency Care – #15 and Urgently Needed Care – #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists and hospitals.</p> <p><b>In and Out-of-Network</b> You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p><b>Out of Service Area</b> Plan covers you when you travel in the U.S.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>General</b> \$80 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>General</b> Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1 (800) MEDICARE (1-800-633-4227). TTY users should call 1 (877) 486-2048. You may also call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing. \$50 yearly deductible. Contact the plan for services that apply.</p> <p><b>In-Network</b> \$3,400 out-of-pocket limit. All plan services included.</p> <p><b>In and Out-of-Network</b> \$3,400 out-of-pocket limit. All plan services included.</p>	<p><b>General</b> \$45 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>General</b> Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1 (800) MEDICARE (1-800-633-4227). TTY users should call 1 (877) 486-2048. You may also call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778.</p> <p>This plan covers all Medicare-covered preventive services with zero cost sharing.</p> <p><b>In-Network</b> \$2,500 out-of-pocket limit. All plan services included.</p> <p><b>In and Out-of-Network</b> \$2,500 out-of-pocket limit. All plan services included.</p>
<p><b>In-Network</b> No referral required for network doctors, specialists and hospitals.</p> <p><b>In and Out-of-Network</b> You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p><b>Out of Service Area</b> Plan covers you when you travel in the U.S.</p>	<p><b>In-Network</b> No referral required for network doctors, specialists and hospitals.</p> <p><b>In and Out-of-Network</b> You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p><b>Out of Service Area</b> Plan covers you when you travel in the U.S.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>SUMMARY OF BENEFITS</b>		
<i>Inpatient Care</i>		
<p><b>3 - Inpatient Hospital Care</b></p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010, the amounts for each benefit period were:            Days 1 - 60: \$1,100 deductible.            Days 61 - 90: \$275 per day.            Days 91 - 150: \$550 per lifetime reserve day.            These amounts will change for 2011.            Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b>            No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays:            Days 1-5: \$150 copay per day            Days 6-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b>            For hospital stays:            Days 1-5: \$250 copay per day.            Days 6 and beyond: \$0 copay per day.</p>
<p><b>4 - Inpatient Mental Health Care</b></p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b>            You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays:            Days 1-5: \$150 copay per day            Days 6-90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b>            For hospital stays: Days 1-5: \$250 copay per day.            Days 6-190: \$0 copay per day.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b> No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays: Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b> For hospital stays: Days 1-5: \$300 copay per day.</p> <p>Days 6 and beyond: \$0 copay per day</p>	<p><b>In-Network</b> No limit to the number of days covered by the plan each benefit period.</p> <p>For Medicare-covered hospital stays: Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b> For hospital stays: Days 1-5: \$300 copay per day.</p> <p>Days 6 and beyond: \$0 copay per day</p>
<p><b>In-Network</b> You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays: Days 1-5: \$200 copay per day</p> <p>Days 6-90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b> For hospital stays: Days 1-5: \$300 copay per day.</p> <p>Days 6-190: \$0 copay per day.</p>	<p><b>In-Network</b> You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>For Medicare-covered hospital stays: Days 1-5: \$200 copay per day</p> <p>Days 6-90: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><b>Out-of-Network</b> For hospital stays: Days 1-5: \$300 copay per day.</p> <p>Days 6-190: \$0 copay per day.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>5 - Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day. Days 21 - 100: \$137.50 per day. These amounts will change for 2011.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays: Days 1-5: \$0 copay per day Days 6-25: \$30 copay per day Days 26 - 100: \$0 copay per day</p> <p><b>Out-of-Network</b> For each SNF stay: Days 1-5: \$20 copay per day Days 6-25: \$40 copay per day Days 26 - 100: \$0 copay per day</p>
<p><b>6 - Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered home health visits.</p> <p><b>Out-of-Network</b> 10% for home health visits.</p>
<p><b>7 - Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays: Days 1-5: \$10 copay per day Days 6-25: \$35 copay per day Days 26 - 100: \$0 copay per day</p> <p><b>Out-of-Network</b> For each SNF stay: Days 1-5: \$30 copay per day Days 6-25: \$50 copay per day Days 26 - 100: \$0 copay per day</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays: Days 1-5: \$10 copay per day Days 6-25: \$35 copay per day Days 26 - 100: \$0 copay per day</p> <p><b>Out-of-Network</b> For each SNF stay: Days 1-5: \$30 copay per day Days 6-25: \$50 copay per day Days 26 - 100: \$0 copay per day</p>
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 10% of the cost for each Medicare-covered home health visit.</p> <p><b>Out-of-Network</b> 20% for home health visits.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 10% of the cost for each Medicare-covered home health visit.</p> <p><b>Out-of-Network</b> 20% for home health visits.</p>
<p><b>General</b> You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>Outpatient Care</b>		
<b>8 - Doctor Office Visits</b>	20% coinsurance.	<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>Out-of-Network</b> \$25 copay for each primary care doctor visit.</p> <p>\$25 copay for each specialist visit.</p>
<b>9 - Chiropractic Services</b>	Routine care not covered.  20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	<p><b>In-Network</b> \$10 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>Out-of-Network</b> \$25 copay for chiropractic benefits.</p>
<b>10 - Podiatry Services</b>	Routine care not covered.  20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<p><b>In-Network</b> \$25 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> \$25 copay for podiatry benefits.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$15 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$35 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>Out-of-Network</b> \$35 copay for each primary care doctor visit.</p> <p>\$35 copay for each specialist visit.</p>	<p><b>General</b> See “Physical Exams,” for more information.</p> <p><b>In-Network</b> \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$15 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$35 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>Out-of-Network</b> \$35 copay for each primary care doctor visit.</p> <p>\$35 copay for each specialist visit.</p>
<p><b>In-Network</b> \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>Out-of-Network</b> \$35 copay for chiropractic benefits.</p>	<p><b>In-Network</b> \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>Out-of-Network</b> \$35 copay for chiropractic benefits.</p>
<p><b>In-Network</b> \$35 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> \$35 copay for podiatry benefits.</p>	<p><b>In-Network</b> \$35 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>Out-of-Network</b> \$35 copay for podiatry benefits.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>11 - Outpatient Mental Health Care</b>	45% coinsurance for most outpatient mental health services.	<p><b>In-Network</b> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>Out-of-Network</b> \$25 copay for Mental Health benefits. \$25 copay for Mental Health benefits with a psychiatrist.</p>
<b>12 - Outpatient Substance Abuse Care</b>	20% coinsurance.	<p><b>In-Network</b> \$25 copay for Medicare-covered individual or group visits.</p> <p><b>Out-of-Network</b> \$25 copay for outpatient substance abuse benefits.</p>
<b>13 – Outpatient Services/Surgery</b>	20% coinsurance for the doctor.  Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible.  20% coinsurance for ambulatory surgical center facility charges.	<p><b>In-Network</b> \$100 copay for each Medicare-covered ambulatory surgical center visit.                       \$0 to \$100 copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>Out-of-Network</b> \$200 copay for ambulatory surgical center benefits.                       \$0 to \$200 copay for outpatient hospital facility benefits.</p>
<b>14 - Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance.	<p><b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.</p> <p><b>Out-of-Network</b> \$100 copay for ambulance benefits.</p>
<b>15 - Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor.  Specified copayment for outpatient hospital emergency room (ER) facility charge.  ER Copay cannot exceed Part A inpatient hospital deductible.  You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.  NOT covered outside the U.S. except under limited circumstances.	<p><b>General</b> \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the emergency room visit.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b> \$35 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>Out-of-Network</b> \$35 copay for Mental Health benefits.  \$35 copay for Mental Health benefits with a psychiatrist.</p>	<p><b>In-Network</b> \$35 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>Out-of-Network</b> \$35 copay for Mental Health benefits.  \$35 copay for Mental Health benefits with a psychiatrist.</p>
<p><b>In-Network</b> \$35 copay for Medicare-covered individual or group visits.</p> <p><b>Out-of-Network</b> \$35 copay for outpatient substance abuse benefits.</p>	<p><b>In-Network</b> \$35 copay for Medicare-covered individual or group visits.</p> <p><b>Out-of-Network</b> \$35 copay for outpatient substance abuse benefits.</p>
<p><b>In-Network</b> \$175 copay for each Medicare-covered ambulatory surgical center visit.  \$0 to \$175, copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>Out-of-Network</b> \$225 copay for outpatient hospital facility benefits.  \$0 to \$225 copay for ambulatory surgical center benefits.</p>	<p><b>In-Network</b> \$175 copay for each Medicare-covered ambulatory surgical center visit.  \$0 to \$175 copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>Out-of-Network</b> \$225 copay for outpatient hospital facility benefits.  \$0 to \$225 copay for ambulatory surgical center benefits.</p>
<p><b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.</p> <p><b>Out-of-Network</b> \$100 copay for ambulance benefits</p>	<p><b>In-Network</b> \$100 copay for Medicare-covered ambulance benefits.</p> <p><b>Out-of-Network</b> \$100 copay for ambulance benefits</p>
<p><b>General</b> \$50 copay for Medicare-covered emergency room visits.</p> <p>This amount applies toward your in and out-of-network plan deductible.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p><b>General</b> \$50 copay for Medicare-covered emergency room visits.</p> <p>This amount applies toward your in and out-of-network plan deductible.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the emergency room visit.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>16 - Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay.  NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b> \$25 copay for Medicare-covered urgently needed care visits.  If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>
<p><b>17 – Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)</p>	<p>20% coinsurance.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$25 copay for Medicare-covered Occupational Therapy visits.  \$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.  \$25 copay for Medicare-covered Cardiac Rehab services.</p> <p><b>Out-of-Network</b> \$25 copay for Occupational Therapy benefits.  \$25 copay for Physical and/or Speech and Language Therapy visits.  \$25 copay for Cardiac Rehab services.</p>
<p><b><i>Outpatient Medical Services and Supplies</i></b></p>		
<p><b>18 - Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 10% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 20% of the cost for durable medical equipment.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>General</b> \$35 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>	<p><b>General</b> \$35 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 48-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$35 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$35 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$35 copay for Medicare-covered Cardiac Rehab services.</p> <p><b>Out-of-Network</b> \$35 copay for Occupational Therapy benefits.</p> <p>\$35 copay for Physical and/or Speech and Language Therapy visits.</p> <p>\$35 copay for Cardiac Rehab services.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$35 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$35 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$35 copay for Medicare-covered Cardiac Rehab services.</p> <p><b>Out-of-Network</b> \$35 copay for Occupational Therapy benefits.</p> <p>\$35 copay for Physical and/or Speech and Language Therapy visits.</p> <p>\$35 copay for Cardiac Rehab services.</p>
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 30% of the cost for durable medical equipment.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 30% of the cost for durable medical equipment.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>19 - Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 10% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 20% of the cost for prosthetic devices.</p>
<p><b>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training, retinal exam/ glaucoma test, and foot exam/therapeutic soft shoes)</p>	<p>20% coinsurance.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p><b>Out-of-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>
<p><b>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p><b>Lab Services:</b> Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare <b>does not</b> cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered: - lab services. - diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered x-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 30% of the cost for prosthetic devices.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 20% of the cost for Medicare-covered items.</p> <p><b>Out-of-Network</b> 30% of the cost for prosthetic devices.</p>
<p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p><b>Out-of-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p><b>In-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p><b>Out-of-Network</b> \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>
<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered: - lab services. - diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered x-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> \$0 copay for Medicare-covered: - lab services. - diagnostic procedures and tests.</p> <p>0% of the cost for Medicare-covered x-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>10% of the cost for Medicare-covered therapeutic radiology services.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b> (continued)		<b>Out-of-Network</b> \$0 copay for diagnostic procedures, tests, and lab services.  10% of the cost for outpatient x-rays.  20% of the cost for therapeutic radiology services.  30% of the cost for diagnostic radiology services.
<b>Preventive Services</b>		
<b>22 - Bone Mass Measurement</b>	No coinsurance, copayment or deductible.  Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.  <b>Out-of-Network</b> \$0 copay for Medicare-covered bone mass measurement.
<b>23 – Colorectal Screening Exams</b>	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.  Covered when you are high risk or when you are age 50 and older.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.  <b>Out-of-Network</b> \$0 copay for colorectal screenings.
<b>24 – Immunizations</b> (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu, Pneumonia and Hepatitis B vaccines.  You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.  \$0 copay for Hepatitis B vaccine.  No referral needed for Flu and Pneumonia vaccines.  <b>Out-of-Network</b> \$0 copay for immunizations.
<b>25 - Mammograms (Annual Screening)</b>	No coinsurance, copayment or deductible.  No referral needed.  Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.  <b>Out-of-Network</b> \$0 copay for screening mammograms.

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Out-of-Network</b> 20% of the cost for outpatient x-rays.</p> <p>20% of the cost for therapeutic radiology services.</p> <p>30% of the cost for diagnostic radiology services.</p> <p>\$0 copay for diagnostic procedures, tests, and lab services.</p>	<p><b>Out-of-Network</b> 20% of the cost for outpatient x-rays.</p> <p>20% of the cost for therapeutic radiology services.</p> <p>30% of the cost for diagnostic radiology services.</p> <p>\$0 copay for diagnostic procedures, tests, and lab services.</p>
<p><b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.</p> <p><b>Out-of-Network</b> \$0 copay for Medicare-covered bone mass measurement.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered bone mass measurement.</p> <p><b>Out-of-Network</b> \$0 copay for Medicare-covered bone mass measurement.</p>
<p><b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.</p> <p><b>Out-of-Network</b> \$0 copay for colorectal screenings</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.</p> <p><b>Out-of-Network</b> \$0 copay for colorectal screenings</p>
<p><b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p> <p><b>Out-of-Network</b> \$0 copay for immunizations.</p>	<p><b>In-Network</b> \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p> <p><b>Out-of-Network</b> \$0 copay for immunizations.</p>
<p><b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.</p> <p><b>Out-of-Network</b> \$0 copay for screening mammograms.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered screening mammograms.</p> <p><b>Out-of-Network</b> \$0 copay for screening mammograms.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>26 - Pap Smears and Pelvic Exams</b></p>	<p>No coinsurance, copayment or deductible for Pap smears.</p> <p>No coinsurance, copayment or deductible for Pelvic and clinical breast exams.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>Out-of-Network</b> \$0 copay for pap smears and pelvic exams.</p>
<p><b>27 - Prostate Cancer Screening Exams</b></p>	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% co-insurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening.</p> <p><b>Out-of-Network</b> \$0 copay for prostate cancer screening.</p>
<p><b>28 – End-Stage Renal Disease</b></p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b> 10% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Out-of-Network</b> \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>10% of the cost for renal dialysis.</p>
<p><b>29 – Prescription Drugs</b></p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>0% to 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>10% of the cost for Part B-covered chemotherapy drugs.</p> <p>0% to 10% of the cost for Part B drugs out-of-network.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>Out-of-Network</b> \$0 copay for pap smears and pelvic exams.</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>Out-of-Network</b> \$0 copay for pap smears and pelvic exams.</p>
<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening.</p> <p><b>Out-of-Network</b> \$0 copay for prostate cancer screening</p>	<p><b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening.</p> <p><b>Out-of-Network</b> \$0 copay for prostate cancer screening</p>
<p><b>In-Network</b> 10% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Out-of-Network</b> 10% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>In-Network</b> 10% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p><b>Out-of-Network</b> 10% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>
<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>10% to 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>10% to 20% of the cost for Part B drugs out-of-network.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b></p> <p>Most drugs not covered.</p> <p>10% to 20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>10% to 20% of the cost for Part B drugs out-of-network.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p>29 – Prescription Drugs (continued)</p>		<p><b>Home Infusion Drugs, Supplies, and Services</b>            \$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.</p> <p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b>            This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.regence.com/medicare">www.regence.com/medicare</a> on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>– have limited incomes,</li> <li>– live in long term care facilities, or</li> <li>– have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan’s service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Regence MedAdvantage + Rx Enhanced (PPO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://www.Medicare.gov">Medicare.gov</a>.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Home Infusion Drugs, Supplies, and Services</b>                      \$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.</p>	
<p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b>                      This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.regence.com/medicare">www.regence.com/medicare</a> on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> <li>– have limited incomes,</li> <li>– live in long term care facilities, or</li> <li>– have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and D.C.). This means that you will pay the same costsharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan’s service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Regence MedAdvantage + Rx Classic (PPO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s Web site, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://Medicare.gov">Medicare.gov</a>.</p>	<p><b>Drugs covered under Medicare Part D</b></p> <p><b>General</b>                      This plan does not offer prescription drug coverage.</p>



## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Regence MedAdvantage + Rx Enhanced (PPO) approves the exception, you will pay Tier 5: Injectable Drugs cost sharing for that drug.</p> <p><b>In-Network</b> \$0 deductible.</p> <p><b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,840:</p> <p><b>Retail Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 2: Non-Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 3: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 4: Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>- \$75 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$225 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Regence MedAdvantage + Rx Classic (PPO) approves the exception, you will pay Tier 5: Injectable Drugs cost-sharing for that drug.</p> <p><b>In-Network</b> \$100 yearly deductible.</p> <p><b>Initial Coverage</b> After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,840:</p> <p><b>Retail Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$15 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 2: Non-Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 3: Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>- \$35 copay for a one-month (30-day) supply of drugs in this tier.</li> <li>- \$105 copay for a three-month (90-day) supply of drugs in this tier.</li> </ul> <p><b>Tier 4: Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>- \$75 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$225 copay for a three-month (90-day) supply of drugs in this tier\</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>- 30% for a one-month (30-day) supply of drugs in this tier</li> </ul>	

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p><b>Tier 6: Specialty Tier Drugs</b>                      - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Long Term Care Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b>                      - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b>                      - \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b>                      - \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand Drugs</b>                      - \$75 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 5: Injectable Drugs</b>                      - 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 6: Specialty Tier Drugs</b>                      - 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Mail Order</b></p> <p><b>Tier 1: Preferred Generic Drugs</b>                      - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$15 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b>                      - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$105 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b>                      - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$105 copay for a three-month (90-day) supply of drugs in this tier</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Tier 6: Specialty Tier Drugs</b> - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Long Term Care Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b> - \$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b> - \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b> - \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand Drugs</b> - \$75 copay for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 5: Injectable Drugs</b> - 30% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Tier 6: Specialty Tier Drugs</b> - 30% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p><b>Mail Order</b></p> <p><b>Tier 1: Preferred Generic Drugs</b> - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$15 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b> - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$105 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b> - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$105 copay for a three-month (90-day) supply of drugs in this tier</p>	

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p><b>Tier 4: Non-Preferred Brand Drugs</b></p> <ul style="list-style-type: none"> <li>- \$75 copay for a one-month (30-day) supply of drugs in this tier</li> <li>- \$225 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p><b>Tier 5: Injectable Drugs</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Tier 6: Specialty Tier Drugs</b></p> <ul style="list-style-type: none"> <li>- 33% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Additional Coverage Gap</b> You pay the following:</p> <p><b>Retail Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of all drugs covered in this tier</li> <li>- \$15 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (31-day) supply of all drugs covered in this tier</li> </ul> <p><b>Mail Order</b></p> <p><b>Tier 1: Preferred Generic Drugs</b></p> <ul style="list-style-type: none"> <li>- \$5 copay for a one-month (30-day) supply of all drugs covered in this tier</li> <li>- \$15 copay for a three-month (90-day) supply of all drugs covered in this tier</li> </ul> <p>After your total yearly drug costs reach \$2,840, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 93% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Tier 4: Non-Preferred Brand Drugs</b>                      - \$75 copay for a one-month (30-day) supply of drugs in this tier</p> <p>- \$225 copay for a three-month (90-day) supply of drugs in this tier</p> <p><b>Tier 5: Injectable Drugs</b>                      - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 6: Specialty Tier Drugs</b>                      - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Coverage Gap</b>                      After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,550.</p>	



## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p><b>Catastrophic Coverage</b>                      After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul> <p><b>Out-of-Network</b>                      Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal costsharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from Regence MedAdvantage + Rx Enhanced (PPO).</p> <p><b>Out-of-Network Initial Coverage</b>                      You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:</p> <p><b>Tier 1: Preferred Generic Drugs</b>                      - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b>                      - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b>                      - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand Drugs</b>                      - \$75 copay for a one-month (30-day) supply of drugs in this tier</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul> <p><b>Out-of-Network</b> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal costsharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Regence MedAdvantage + Rx Classic (PPO).</p> <p><b>Out-of-Network Initial Coverage</b> After you pay your yearly deductible, You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:</p> <p><b>Tier 1: Preferred Generic Drugs</b> - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b> - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 3: Preferred Brand Drugs</b> - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 4: Non-Preferred Brand Drugs</b> - \$75 copay for a one-month (30-day) supply of drugs in this tier</p>	

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p><b>Tier 5: Injectable Drugs</b>                      - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 6: Specialty Tier Drugs</b>                      - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Additional Out-of-Network Coverage Gap</b>                      You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><b>Tier 1: Preferred Generic Drugs</b>                      - \$5 copay for a one-month (30-day) supply of all drugs covered in this tier</p> <p><b>Tier 2: Non-Preferred Generic Drugs</b>                      You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Tier 3: Preferred Brand Drugs</b>                      You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>Tier 5: Injectable Drugs</b> - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Tier 6: Specialty Tier Drugs</b> - 30% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><b>Out-of-Network Coverage Gap</b> You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p>	



## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>29 – Prescription Drugs (continued)</b></p>		<p><b>Tier 4: Non-Preferred Brand Drugs</b>            You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Tier 5: Injectable Drugs</b>            You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Tier 6: Specialty Tier Drugs</b>            You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Out-of-Network Catastrophic Coverage</b>            After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> <li>- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx  
Classic (PPO)

Regence MedAdvantage (PPO)

### Out-of-Network

#### Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or
- 5% coinsurance.

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<b>30 - Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>In-Network</b>                      \$25 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> <li>- 20% of the cost for up to 2 oral exams every year</li> <li>- 20% of the cost for up to 2 cleanings every year</li> <li>- 20% of the cost for up to 2 dental x-rays every year</li> </ul> <p><b>Out-of-Network</b>                      \$25 copay for comprehensive dental benefits.</p> <p>20% of the cost for preventive dental benefits.</p> <p><b>In and Out-of-Network</b>                      \$500 plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p>
<b>31 - Hearing Services</b>	Routine hearing exams and hearing aids not covered.  20% coinsurance for diagnostic hearing exams.	<p><b>In-Network</b>                      In general, routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> <li>- \$25 copay for Medicare-covered diagnostic hearing exams.</li> </ul> <p><b>Out-of-Network</b>                      \$25 copay for hearing exams.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b> \$35 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> <li>- 20% of the cost for up to 2 oral exams every year</li> <li>- 20% of the cost for up to 2 cleanings every year</li> <li>- 20% of the cost for up to 2 dental x-rays every year</li> </ul> <p><b>Out-of-Network</b> \$35 copay for comprehensive dental benefits.</p> <p>20% of the cost for preventive dental benefits.</p> <p><b>In and Out-of-Network</b> \$500 plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p>	<p><b>In-Network</b> \$35 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> <li>- 20% of the cost for up to 2 oral exams every year</li> <li>- 20% of the cost for up to 2 cleanings every year</li> <li>- 20% of the cost for up to 2 dental x-rays every year</li> </ul> <p><b>Out-of-Network</b> \$35 copay for comprehensive dental benefits.</p> <p>20% of the cost for preventive dental benefits.</p> <p><b>In and Out-of-Network</b> \$500 plan coverage limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p>
<p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> <li>- \$35 copay for Medicare-covered diagnostic hearing exams.</li> </ul> <p><b>Out-of-Network</b> \$35 copay for hearing exams.</p>	<p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> <li>- \$35 copay for Medicare-covered diagnostic hearing exams.</li> </ul> <p><b>Out-of-Network</b> \$35 copay for hearing exams.</p>



## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>32 - Vision Services</b></p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>In-Network</b>                      \$0 copay for                      - one pair of eye-glasses or contact lenses after cataract surgery</p> <p>\$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$25 copay for up to one routine eye exam every year.</p> <p>\$200 plan coverage limit for eye wear every year.</p> <p><b>Out-of-Network</b>                      \$25 copay for eye exams.</p> <p>\$0 copay for eye wear.</p>
<p><b>33 - Welcome to Medicare; and Annual Wellness Visit</b></p>	<p>When you join Medicare Part B, then you are eligible as follows.</p> <p>During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit.</p> <p>After your first 12 months, you can get one Annual Wellness visit every 12 months.</p> <p>There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit.</p> <p>The Welcome to Medicare exam does not include lab tests.</p>	<p><b>In-Network</b>                      \$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p> <p>\$0 copay for routine exams</p> <p>Limited to one exam every year.</p> <p><b>Out-of-Network</b>                      \$0 copay for routine exams.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b>                      \$0 copay for                      - one pair of eye-glasses or contact lenses after cataract surgery</p> <p>\$0 to \$35 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$35 copay for up to one routine eye exam every year.</p> <p>\$100 plan coverage limit for eye wear every year.</p> <p><b>Out-of-Network</b>                      \$35 copay for eye exams.</p> <p>\$0 copay for eye wear.</p>	<p><b>In-Network</b>                      \$0 copay for                      - one pair of eye-glasses or contact lenses after cataract surgery</p> <p>\$0 to \$35 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>- \$35 copay for up to one routine eye exam every year.</p> <p>\$100 plan coverage limit for eye wear every year.</p> <p><b>Out-of-Network</b>                      \$35 copay for eye exams.</p> <p>\$0 copay for eye wear.</p>
<p><b>In-Network</b>                      \$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p> <p>\$0 copay for routine exams</p> <p>Limited to one exam every year.</p> <p><b>Out-of-Network</b>                      \$0 copay for routine exams.</p>	<p><b>In-Network</b>                      \$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p> <p>\$0 copay for routine exams</p> <p>Limited to one exam every year.</p> <p><b>Out-of-Network</b>                      \$0 copay for routine exams.</p>

## Section II – Summary of Benefits (continued)

BENEFIT	Original Medicare	Regence MedAdvantage + Rx Enhanced (PPO)
<p><b>34 - Health/Wellness Education</b></p>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p> <p>\$0 copay for the HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p>	<p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nursing Hotline</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p><b>Out-of-Network</b> \$0 copay for Health and Wellness services.</p>

## Section II – Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage (PPO)
<p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nursing Hotline</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p><b>Out-of-Network</b> \$0 copay for Health and Wellness services.</p>	<p><b>In-Network</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>- Written health education materials, including Newsletters</li> <li>- Nursing Hotline</li> </ul> <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p><b>Out-of-Network</b> \$0 copay for Health and Wellness services.</p>

## Summary of Benefits

## Section III

# Understanding your Benefits

This Summary of Benefits is an important brochure for explaining coverage options, so the content is regulated by the Centers for Medicare & Medicaid Services (CMS). This Section III was developed to help provide more insight and information on the descriptions in the tables starting on page 8 of this brochure. Please be sure to read the tables carefully to understand your coverage options.

### **Premium and other important information – page 8**

Regence MedAdvantage offers additional benefits not included in Medicare. But members never lose their Medicare benefits and must continue to pay their Medicare Part B premium. With Regence MedAdvantage + Rx Enhanced and Regence MedAdvantage + Rx Classic, you receive Medicare Part D prescription drug coverage.

The monthly premiums for these plans are:

Regence MedAdvantage + Rx Enhanced: \$127 premium

Regence MedAdvantage + Rx Classic: \$80 premium

Regence MedAdvantage : \$45 premium

### **Check your Regence MedAdvantage Information Brochure**

The Information Brochure that accompanied this summary of benefits will help answer many of your questions. The Information Brochure provides handy benefit summaries, a coverage area map, a glossary of terms, and answers to frequently asked questions.

**Deductibles:** All medical deductibles are combined deductibles—which means charges you pay both inside and outside the network accumulate toward the same medical deductible. Once you've met your deductible, your plan begins to cover your care.

Part D prescription drug coverage may have a separate deductible.

Deductible(s) for Regence MedAdvantage coverage are as follows:

**Regence MedAdvantage + Rx Enhanced:** \$0 deductible Medical/\$0 deductible Part D

**Regence MedAdvantage + Rx Classic:** \$50 deductible Medical/\$100 deductible Part D

**Regence MedAdvantage :** \$0 deductible Medical (no Part D coverage)

Please note that many preventive care benefits are not subject to the deductible. See page 2 for more information.

**Out-of-pocket maximum:** All plans have annual out-of-pocket maximums.

**Regence MedAdvantage + Rx Enhanced:** \$2,500 out-of-pocket maximum

**Regence MedAdvantage + Rx Classic:** \$3,400 out-of-pocket maximum

**Regence MedAdvantage :** \$2,500 out-of-pocket maximum

The total amount you pay in coinsurance or copays in a calendar year before the plan picks up the full cost of covered medical expenses is your out-of-pocket maximum. With Regence MedAdvantage, your cost-sharing amounts contribute to that maximum. For 2011, there are two maximum out-of-pocket (OOP) amounts. The in-network OOP maximum is either \$2,500 or \$3,400, depending on which plan you have. This is the maximum you pay for covered services received from in-network providers. The catastrophic OOP maximum is also \$2,500 or \$3,400. This is the maximum you pay for covered services received from both in-network and out-of-network providers. **You only have to meet one of the OOP Maximums to get 100% coverage and no out-of-pocket costs for covered services for the remainder of the year.** Once you've reached the maximum, benefits will be paid as specified. If you choose a plan with a deductible, your out-of-pocket expenses will start accumulating toward the maximum once you've met the deductible.

Part D prescription drug cost-sharing amounts vary with prescription drug costs expended. Refer to the table on page 24 for details.

### **Doctor and Hospital Choice – page 8**

With Regence MedAdvantage, you are free to use any doctor, specialist or hospital that accepts Medicare and still receive coverage. When choosing an in-network provider from our vast network, you typically receive better benefits and lower out-of-pocket costs.

Some benefits differentiate between primary and specialty care. In other words, you pay less when you see a primary care provider. The following provider types are considered “primary care”:

- General practice
- Family practice
- Internal medicine
- Geriatric medicine
- Gynecology
- Nurse practitioner
- Physician assistant

Other provider types are considered specialists. You'll pay the specialty care copay for care you receive from those providers.

### **Doctor Office Visits – page 14**

You pay a \$10 copay for primary care services and a \$25 copay for specialty services with Regence MedAdvantage + Rx Enhanced; and a \$15 copay for primary care services and a \$35 copay for specialty services with Regence MedAdvantage + Rx Classic and Regence MedAdvantage when using in-network benefits.

### **Inpatient Hospital Care – page 10**

Regence MedAdvantage covers you for unlimited days for a Medicare-covered stay after you pay a copay per benefit period. In a network facility, you pay a \$150 copay per day up to a maximum of \$750 per benefit period with Regence MedAdvantage + Rx Enhanced. With Regence MedAdvantage + Rx Classic and Regence MedAdvantage, you pay a \$200 copay a day in a network facility up to a maximum of \$1,000 per benefit period. Authorization rules may apply.

### **Skilled Nursing Facility Care – page 12**

You pay a \$0 copay for days 1 through 5, a \$30 copay per day for days 6 through 25, and a \$0 copay per day for days 26 through 100 at a network facility with Regence MedAdvantage + Rx Enhanced. With Regence MedAdvantage + Rx Classic and Regence MedAdvantage you pay a \$10 copay per day for days 1 through 5, a \$35 copay per day for days 6 through 25, and a \$0 copay per day for days 26 through 100 at a network facility. Authorization rules may apply. No benefits are available after the 100 day maximum.

### **Emergency Care – page 16**

Regence MedAdvantage will cover you for medical emergencies anywhere in the world. There is a \$50 copay for emergency room services. The emergency room copay is waived if you are admitted within 48 hours.

### **Diagnostic Tests, X-rays, and Lab Services – page 20 and page 21**

Your doctor may order specific exams to help diagnose your health care needs. You are covered with no copay for in-network x-rays and with 10% coinsurance for in-network radiation therapy. You are covered 20% coinsurance for MRI, CT, PET and nuclear medicine (authorization rules may apply to MRI, CT, PET and nuclear medicine). Lab charges are covered without a coinsurance amount.

**Contact us today for more information**

**Regence MedAdvantage Customer Service  
1 (800) 541-8981 TTY: 711**

**FROM Nov. 15 through March 1: HOURS** 8 a.m. to 8 p.m., seven days a week

**AFTER March 1: HOURS** 8 a.m. to 8 p.m., Monday through Friday

Please leave a message on Saturdays, Sundays and holidays,  
and we'll return your call the next business day.

**[www.regence.com/medicare](http://www.regence.com/medicare)**

**Prescription Drugs/Tiered Pharmacy Benefit – page 24**

Coverage for prescription drugs is provided by Regence MedAdvantage + Rx Enhanced and Regence MedAdvantage + Rx Classic.

**Phase 1  
DEDUCTIBLE/INITIAL COVERAGE**

ENHANCED	CLASSIC
<ul style="list-style-type: none"> <li>● <b>\$0 deductible</b></li> <li>● Your cost share is: <b>\$5/\$35/\$35/\$75/33%/33%</b> per prescription depending on the tier <i>(Please see more detailed explanation of drug tiers on page 11.)</i></li> </ul>	<ul style="list-style-type: none"> <li>● <b>\$100 deductible</b></li> <li>● After your deductible, your share is: <b>\$5/\$35/\$35/\$75/30%/30%</b> per prescription depending on the tier <i>(Please see more detailed explanation of drug tiers on page 11.)</i></li> </ul>



After you've paid your yearly deductible (if you have one) and the yearly drug costs (paid by you and Regence MedAdvantage) reach **\$2,840**, you enter the Coverage Gap.

**Phase 2  
COVERAGE GAP**

ENHANCED	CLASSIC
<p>You pay \$5 copay per prescription for each 30-day supply of Tier 1 preferred generics; 93% coinsurance for all other covered Part D generics during the Coverage Gap; and 50% for some brand name drugs discounted through the Coverage Gap Discount Program (see page 9)</p>	<p>You pay 93% coinsurance for all covered Part D generics, and 50% for some brand name drugs discounted through the coverage Gap Discount Program (see page 9).</p>



After your out-of-pocket costs (paid by you in all phases and by the drug manufacturer(s) in the coverage gap) reach **\$4,550** you go to Catastrophic Coverage for the remainder of the year.

**Phase 3  
CATASTROPHIC**

ENHANCED	CLASSIC
<p>You pay the greater of \$2.50/\$6.30 copay or 5% coinsurance per prescription depending on the tier.</p>	<p>You pay the greater of \$2.50/\$6.30 copay or 5% coinsurance per prescription depending on the tier.</p>

***Benefit period: Jan. 1 through Dec. 31 each year***

Deductibles, copays and coinsurance are based on a 30-day supply of medications (31-day for long-term care) and are effective Jan. 1 through Dec. 31 each year.

**Mail-order supplies:** We provide a convenient mail-order service for up to 90-day supplies of most medications. Extended-day supplies are also available on most medications at retail network pharmacies that have agreed to dispense up to a 90-day supply. (Medications in Tier 5 and 6 are limited to a 30-day supply.) To find a retail network pharmacy that can dispense an extended-day supply of medications, please refer to our Pharmacy Directory, visit our website or call our Customer Service department at the number listed on the back cover.

**Tiered Pharmacy Benefit:** You'll pay 100% for most prescription drugs unless you have Regence MedAdvantage + Rx Enhanced or Regence MedAdvantage + Rx Classic. If you have the drug coverage, you'll pay your annual deductible and prescription medication copay/coinsurance as follows:

	Regence MedAdvantage + Rx Enhanced	Regence MedAdvantage + Rx Classic
<b>Deductible</b>	<b>\$0</b>	<b>\$100</b>
<b>Tier 1:</b> Copay for preferred generics	\$5	\$5
<b>Tier 2:</b> Copay for non-preferred generics*	\$35	\$35
<b>Tier 3:</b> Copay for preferred brand drugs	\$35	\$35
<b>Tier 4:</b> Copay for non-preferred brand drugs	\$75	\$75
<b>Tier 5*:</b> Coinsurance for injectable drugs	33%	30%
<b>Tier 6*:</b> Coinsurance for specialty tier drugs	33%	30%
Coverage during the "Coverage Gap" (To learn more about the Coverage Gap, see page 9.)	You pay \$5 copay per prescription for each 30-day supply for Tier 1 preferred generics; 93% coinsurance for all other covered Part D generics; and 50% for some brand name drugs discounted through the Coverage Gap Discount Program. Once your out-of-pocket costs (including what you've paid in all phases and what the drug manufacturers have paid for covered brand drugs during the coverage gap) reach \$4,550, you go to Catastrophic coverage	You pay 93% coinsurance for covered Part D generics; and 50% for some brand name drugs discounted through the Coverage Gap Discount Program. Once your out-of-pocket costs (including what you've paid in all phases and what the drug manufacturers have paid for covered brand drugs during the coverage gap) reach \$4,550, you go to Catastrophic coverage

\*Tiers 5 and 6 products are limited to a 30-day supply and may contain generic products. Deductibles, copays and coinsurance amounts are based on a 30-day supply of medications (31-day supply for long-term care) and are effective Jan. 1, 2011, through Dec. 31, 2011.

**Copays and coinsurance listed above are applicable until your total annual drug costs reach \$2,840.**

**Dental Services – page 40**

With all **Regence MedAdvantage** plans, you're covered at 80% for preventive dental services (up to \$500 per year), such as routine cleanings (the kind that are recommended twice a year), X-rays and exams. Just go to your dentist and show your member card—that's the only card you'll need. Remember that if your dentist is out-of-network, you may have a higher coinsurance amount. This coverage does not include other dental services, such as full-mouth debridement, fillings, crowns, bridges and root canals.

**Hearing Services – page 40**

In general, you pay 100% for routine hearing exams and hearing aids. For Medicare-covered hearing exams (diagnostic hearing exams), you pay a \$10 copay for in-network services from a primary care provider and a \$25 copay for in-network services from a specialty care provider with Regence MedAdvantage + Rx Enhanced. With Regence MedAdvantage + Rx Classic and Regence MedAdvantage, you pay a \$15 copay for in-network services from a primary care provider and a \$35 copay for in-network services from a specialty care provider.

**Vision Services – page 42**

With all Regence MedAdvantage plans, you are eligible for non-Medicare covered, routine vision exams every year. You pay a \$25 copay when services are obtained in-network with Regence MedAdvantage + Rx Enhanced; with Regence MedAdvantage + Rx Classic and Regence MedAdvantage, you pay a \$35 copay for in-network services. For routine vision hardware, we pay \$200 every year with Regence MedAdvantage + Rx Enhanced; with Regence MedAdvantage + Rx Classic and Regence MedAdvantage we pay \$100 every year. Members with diabetes are eligible for a dilated eye exam once every calendar year. On all plans, Medicare-covered services include exams to diagnose and treat disease and conditions of the eye. Also included is one pair of eyeglasses or contact lenses after cataract surgery. If you see an out-of-network provider, cost sharing may apply if provider does not accept Medicare assignment.

*Regence MedAdvantage is a health plan with a Medicare contract. Benefits, formularies, premiums, coinsurance/copay amounts and provider or pharmacy networks may change in the upcoming contract year. Your Medicare Advantage (PPO) plan may not be available next year because by law, CMS may refuse to renew our contract, or Regence can choose not to renew our contract with CMS, or Regence can choose to reduce its service area, which would result in your plan's termination or nonrenewal.*



**Regence MedAdvantage + Rx Enhanced  
Regence MedAdvantage + Rx Classic  
Regence MedAdvantage**

For more information, call 8 a.m. to 5 p.m.,  
Pacific time, Monday through Friday  
toll-free: **1-888-REGENCE (1-888-734-3623)**

**Regence MedAdvantage (PPO) Customer Service  
1 (800) 541-8981 TTY: 711**

**FROM November 15 through March 1:**  
**HOURS** 8 a.m. to 8 p.m., seven days a week

**AFTER March 1:**  
**HOURS** 8 a.m. to 8 p.m., Monday through Friday  
Please leave a message on Saturdays, Sundays and holidays,  
and we will return your call on the next business day.

**PO Box 12625  
Salem, OR 97309-0625**

[www.regence.com/medicare](http://www.regence.com/medicare)

