Summary of Benefits

January 1, 2016 – December 31, 2016

Regence

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)**, or **Regence MedAdvantage Basic (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)** cover and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

Things to Know About **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)**

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

Covered Medical and Hospital Benefits

Prescription Drug Benefits

Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1 (800) 541-8981.

Regence BlueShield of Idaho
is an Independent Licensee of the Blue Cross and Blue Shield Association
H1304_124_09811 Accepted

Things to Know About **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)**

Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.

Regence MedAdvantage + Rx Classic (PPO), **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)**

Phone Numbers and Website

If you are a member of this plan, call toll-free 1 (800) 541-8981.

If you are not a member of this plan, call toll-free 1 (888) 369-3171.

Our website: http://www.regence.com/medicare

Who can join?

To join **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)**, or **Regence MedAdvantage Basic (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Idaho: Bonner, Kootenai, Latah, and Nez Perce; and Washington: Asotin.

Which doctors, hospitals, and pharmacies can I use?

Regence MedAdvantage + Rx Classic (PPO), **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.regence.com/medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and *more*.

Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get *more than what is* covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

Regence MedAdvantage Basic (PPO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, **Regence MedAdvantage Basic (PPO)** does not cover Part D prescription drugs.

Regence MedAdvantage + Rx Classic (PPO), and **Regence MedAdvantage + Rx Enhanced (PPO)** cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.regence.com/medicare.

Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Regence BlueShield of Idaho is a Medicare Advantage Plan with a Medicare contract. Enrollment in Regence BlueShield of Idaho depends on contract renewal.

Summary of Benefits January 1, 2016 - December 31, 2016

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
How much is the monthly premium?	$116 per month. In addition, you must keep paying your Medicare Part B premium.	$201 per month. In addition, you must keep paying your Medicare Part B premium.	$76 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$360 per year for Part D prescription drugs except for drugs listed on Tier 6 which are excluded from the deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $5,000 for services you receive from in-network providers. $8,300 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Covered Medical and Hospital Benefits			
Note: Services with a [1] may require prior authorization.			
Outpatient Care and Services			
Acupuncture	Not covered	Not covered	Not covered
Ambulance[1]	**In-network:** $300 copay **Out-of-network:** $300 copay	**In-network:** $250 copay **Out-of-network:** $250 copay	**In-network:** $300 copay **Out-of-network:** $300 copay
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **In-network:** $20 copay **Out-of-network:** 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **In-network:** $20 copay **Out-of-network:** 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **In-network:** $20 copay **Out-of-network:** 30% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **In-network:** $35 copay **Out-of-network:** 30% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **In-network:** $30 copay **Out-of-network:** 30% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **In-network:** $40 copay **Out-of-network:** 30% of the cost
	Preventive dental services: Cleaning (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Preventive dental services: Cleaning (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Preventive dental services: Cleaning (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Dental Services (cont.)	Dental x-ray(s) (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Dental x-ray(s) (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Dental x-ray(s) (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost
	Oral exam (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Oral exam (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost	Oral exam (for up to 2 every year): **In-network:** 50% of the cost **Out-of-network:** 50% of the cost
	Our plan pays up to $500 every year for preventive dental services from any provider. *Coverage for preventive dental services, including x-rays, is limited to specific dental codes.*	Our plan pays up to $500 every year for preventive dental services from any provider. *Coverage for preventive dental services, including x-rays, is limited to specific dental codes.*	Our plan pays up to $500 every year for preventive dental services from any provider. *Coverage for preventive dental services, including x-rays, is limited to specific dental codes.*
Diabetes Supplies and Services	Diabetes monitoring supplies: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Diabetes monitoring supplies: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Diabetes monitoring supplies: **In-network:** You pay nothing **Out-of-network:** 30% of the cost
	Diabetes self-management training: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Diabetes self-management training: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Diabetes self-management training: **In-network:** You pay nothing **Out-of-network:** 30% of the cost
	Therapeutic shoes or inserts: **In-network:** You pay nothing **Out-of-network:** 30% of the cost *Coverage for diabetes monitoring supplies may be limited to specific manufacturers.*	Therapeutic shoes or inserts: **In-network:** You pay nothing **Out-of-network:** 30% of the cost *Coverage for diabetes monitoring supplies may be limited to specific manufacturers.*	Therapeutic shoes or inserts: **In-network:** You pay nothing **Out-of-network:** 30% of the cost *Coverage for diabetes monitoring supplies may be limited to specific manufacturers.*

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1]	Diagnostic radiology services (such as MRIs, CT scans): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost
	Diagnostic tests and procedures: **In-network:** $10-25 copay, depending on the service **Out-of-network:** 30% of the cost	Diagnostic tests and procedures: **In-network:** $0-15 copay, depending on the service **Out-of-network:** 30% of the cost	Diagnostic tests and procedures: **In-network:** $10-25 copay, depending on the service **Out-of-network:** 30% of the cost
	Lab services: **In-network:** $10-25 copay, depending on the service **Out-of-network:** 30% of the cost	Lab services: **In-network:** $0-15 copay, depending on the service **Out-of-network:** 30% of the cost	Lab services: **In-network:** $10-25 copay, depending on the service **Out-of-network:** 30% of the cost
	Outpatient x-rays: **In-network:** $10 copay **Out-of-network:** 30% of the cost	Outpatient x-rays: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Outpatient x-rays: **In-network:** $10 copay **Out-of-network:** 30% of the cost
	Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** 20% of the cost **Out-of-network:** 30% of the cost
Doctor's Office Visits	Primary care physician visit: **In-network:** $15 copay **Out-of-network:** 30% of the cost	Primary care physician visit: **In-network:** $10 copay **Out-of-network:** 30% of the cost	Primary care physician visit: **In-network:** $15 copay **Out-of-network:** 30% of the cost
	Specialist visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Specialist visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Specialist visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Emergency Care	$75 copay If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$75 copay If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$75 copay If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-network:** $40 copay **Out-of-network:** 30% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Exam to diagnose and treat hearing and balance issues: **In-network:** $30 copay **Out-of-network:** 30% of the cost Hearing aid: **In-network:** $599-899 copay for each hearing aid, depending on the type **Out-of-network:** $599-899 copay for each hearing aid, depending on the type *Limits apply. See your EOC for more information.*	Exam to diagnose and treat hearing and balance issues: **In-network:** $40 copay **Out-of-network:** 30% of the cost

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Home Health Care	**In-network:** You pay nothing **Out-of-network:** 30% of the cost	**In-network:** You pay nothing **Out-of-network:** 30% of the cost	**In-network:** You pay nothing **Out-of-network:** 30% of the cost
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Mental Health Care[1] (cont.)	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. **In-network:** $310 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 **Out-of-network:** 30% of the cost per day for days 1 through 190	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. **In-network:** $280 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 **Out-of-network:** 30% of the cost per day for days 1 through 190	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. **In-network:** $340 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 **Out-of-network:** 30% of the cost per day for days 1 through 190
	Outpatient group therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Outpatient group therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Outpatient group therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
	Outpatient individual therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Outpatient individual therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Outpatient individual therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **In-network:** $35 copay **Out-of-network:** 30% of the cost	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **In-network:** $30 copay **Out-of-network:** 30% of the cost	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **In-network:** $40 copay **Out-of-network:** 30% of the cost

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Outpatient Rehabilitation[1] (cont.)	Occupational therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Occupational therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Occupational therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
	Physical therapy and speech and language therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Physical therapy and speech and language therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Physical therapy and speech and language therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
Outpatient Substance Abuse[1]	Group therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Group therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Group therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
	Individual therapy visit: **In-network:** $35 copay **Out-of-network:** 30% of the cost	Individual therapy visit: **In-network:** $30 copay **Out-of-network:** 30% of the cost	Individual therapy visit: **In-network:** $40 copay **Out-of-network:** 30% of the cost
Outpatient Surgery[1]	Ambulatory surgical center: **In-network:** $150 copay **Out-of-network:** 30% of the cost	Ambulatory surgical center: **In-network:** $150 copay **Out-of-network:** 30% of the cost	Ambulatory surgical center: **In-network:** $200 copay **Out-of-network:** 30% of the cost
	Outpatient hospital: **In-network:** $275 copay **Out-of-network:** 30% of the cost	Outpatient hospital: **In-network:** $275 copay **Out-of-network:** 30% of the cost	Outpatient hospital: **In-network:** $325 copay **Out-of-network:** 30% of the cost
Over-the-Counter Items	Not Covered	Not Covered	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Prosthetic devices: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Prosthetic devices: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost
	Related medical supplies: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Related medical supplies: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	Related medical supplies: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Renal Dialysis[1]	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost	**In-network:** 20% of the cost **Out-of-network:** 30% of the cost
Transportation	Not covered	Not covered	Not covered
Urgently Needed Services	$50 copay	$50 copay	$50 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **In-network:** $0-35 copay, depending on the service **Out-of-network:** 30% of the cost	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **In-network:** $0-30 copay, depending on the service **Out-of-network:** 30% of the cost	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **In-network:** $0-40 copay, depending on the service **Out-of-network:** 30% of the cost
	Routine eye exam (for up to 1 every year): **In-network:** $35 copay **Out-of-network:** $35 copay	Routine eye exam (for up to 1 every year): **In-network:** $30 copay **Out-of-network:** $30 copay	Routine eye exam (for up to 1 every year): **In-network:** $40 copay **Out-of-network:** $40 copay
	Contact lenses: **In-network:** $0 copay **Out-of-network:** $0 copay	Contact lenses: **In-network:** $0 copay **Out-of-network:** $0 copay	Contact lenses: **In-network:** $0 copay **Out-of-network:** $0 copay
	Eyeglass frames (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay	Eyeglass frames (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay	Eyeglass frames (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay
	Eyeglass lenses (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay	Eyeglass lenses (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay	Eyeglass lenses (for up to 1 every year): **In-network:** $0 copay **Out-of-network:** $0 copay

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Vision Services (cont.)	Eyeglasses or contact lenses after cataract surgery: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Eyeglasses or contact lenses after cataract surgery: **In-network:** You pay nothing **Out-of-network:** 30% of the cost	Eyeglasses or contact lenses after cataract surgery: **In-network:** You pay nothing **Out-of-network:** 30% of the cost
	Our plan pays up to $100 every year for contact lenses, eyeglass lenses, and eyeglass frames from any provider.	Our plan pays up to $150 every year for contact lenses, eyeglass lenses, and eyeglass frames from any provider.	Our plan pays up to $100 every year for contact lenses, eyeglass lenses, and eyeglass frames from any provider.
	You are responsible for amounts above the benefit limit. *Reimbursement for out-of-network routine eye exams may be limited.* *$0 copay applies to glaucoma screening only.*	*You are responsible for amounts above the benefit limit.* *Reimbursement for out-of-network routine eye exams may be limited.* *$0 copay applies to glaucoma screening only.*	*You are responsible for amounts above the benefit limit.* *Reimbursement for out-of-network routine eye exams may be limited.* *$0 copay applies to glaucoma screening only.*
Preventive Care	**In-network:** You pay nothing **Out-of-network:** 30% of the cost	**In-network:** You pay nothing **Out-of-network:** 30% of the cost	**In-network:** You pay nothing **Out-of-network:** 30% of the cost
	Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening	Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening	Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Preventive Care	Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) Depression screening Diabetes screenings HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots “Welcome to Medicare” preventive visit (one-time) Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.	Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) Depression screening Diabetes screenings HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots “Welcome to Medicare” preventive visit (one-time) Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.will be covered.	Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) Depression screening Diabetes screenings HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots “Welcome to Medicare” preventive visit (one-time) Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Inpatient Care			
Inpatient Hospital Care[1]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.
	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** $310 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** $280 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network:** $340 copay per day for days 1 through 4 You pay nothing per day for days 5 through 90 You pay nothing per day for days 91 and beyond

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Inpatient Hospital Care[1] (cont.)	**Out-of-network:** 30% of the cost per day for days 1 and beyond	**Out-of-network:** 30% of the cost per day for days 1 and beyond	**Out-of-network:** 30% of the cost per day for days 1 and beyond
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. **In-network:** You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-network:** 30% of the cost per day for days 1 through 100	Our plan covers up to 100 days in a SNF. **In-network:** You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-network:** 30% of the cost per day for days 1 through 100	Our plan covers up to 100 days in a SNF. **In-network:** You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-network:** 30% of the cost per day for days 1 through 100
Prescription Drug Benefits			
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost Other Part B drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	For Part B drugs such as chemotherapy drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost Other Part B drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost	For Part B drugs such as chemotherapy drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost Other Part B drugs[1]: **In-network:** 20% of the cost **Out-of-network:** 30% of the cost

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	Our plan does not cover Part D prescription drugs.

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)				Regence MedAdvantage + Rx Enhanced (PPO)				Regence MedAdvantage Basic (PPO)
Initial Coverage (cont.)	**Standard Retail Cost-Sharing**				**Standard Retail Cost-Sharing**				
	Tier	**One-month supply**	**Two-month supply**	**Three-month supply**	**Tier**	**One-month supply**	**Two-month supply**	**Three-month supply**	
	Tier 1 (Preferred Generic)	$10 copay	$20 copay	$20 copay	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$10 copay	
	Tier 2 (Generic)	$17 copay	$34 copay	$34 copay	Tier 2 (Generic)	$12 copay	$24 copay	$24 copay	
	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay	
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$250 copay	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$250 copay	
	Tier 5 (Specialty Tier)	25% of the cost	Not Offered	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered	
	Tier 6 (Select Care Drugs)	$0	$0	$0	Tier 6 (Select Care Drugs)	$0	$0	$0	

Benefit	Regence MedAdvantage + Rx Classic (PPO)				Regence MedAdvantage + Rx Enhanced (PPO)				Regence MedAdvantage Basic (PPO)
Initial Coverage (cont.)	**Standard Mail Order Cost-Sharing**				**Standard Mail Order Cost-Sharing**				
	Tier	**One-month supply**	**Two-month supply**	**Three-month supply**	**Tier**	**One-month supply**	**Two-month supply**	**Three-month supply**	
	Tier 1 (Preferred Generic)	$10 copay	$20 copay	$20 copay	Tier 1 (Preferred Generic)	$5 copay	$10 copay	$10 copay	
	Tier 2 (Generic)	$17 copay	$34 copay	$34 copay	Tier 2 (Generic)	$12 copay	$24 copay	$24 copay	
	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay	
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$250 copay	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$250 copay	
	Tier 5 (Specialty Tier)	25% of the cost	Not Offered	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Not Offered	
	Tier 6 (Select Care Drugs)	$0	$0	$0	Tier 6 (Select Care Drugs)	$0	$0	$0	
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.				If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.				

Summary of Benefits (continued)

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: 5% of the cost, or $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: 5% of the cost, or $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.	

Benefit	Regence MedAdvantage + Rx Classic (PPO)	Regence MedAdvantage + Rx Enhanced (PPO)	Regence MedAdvantage Basic (PPO)
Optional Benefits *(you must pay an extra premium each month for these benefits)*			
Package 1: Dental Option	Benefits include: Comprehensive Dental	Benefits include: Comprehensive Dental	Benefits include: Comprehensive Dental
How much is the monthly premium?	Additional $27.00 per month. You must keep paying your Medicare Part B premium and your $116.00 monthly plan premium.	Additional $27.00 per month. You must keep paying your Medicare Part B premium and your $201.00 monthly plan premium.	Additional $27.00 per month. You must keep paying your Medicare Part B premium and your $76.00 monthly plan premium.
How much is the deductible?	This package does not have a deductible.	This package does not have a deductible.	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,000 every year. Our plan has additional coverage limits for certain benefits. *Our plan pays 50% of the cost of covered dental services.* *Coverage for dental services is limited to specific dental codes.*	Our plan pays up to $1,000 every year. Our plan has additional coverage limits for certain benefits. *Our plan pays 50% of the cost of covered dental services.* *Coverage for dental services is limited to specific dental codes.*	Our plan pays up to $1,000 every year. Our plan has additional coverage limits for certain benefits. *Our plan pays 50% of the cost of covered dental services.* *Coverage for dental services is limited to specific dental codes.*

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-541-8981. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-541-8981. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-541-8981 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-541-8981。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-541-8981. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-541-8981. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-541-8981 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-541-8981. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-541-8981번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-541-8981. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى بمساعدتك. هذه خدمة مجانية الاتصال بنا على 1-800-145-8981. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-541-8981 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-541-8981. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-541-8981. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-541-8981. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-541-8981. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-541-8981にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Regence