

**2009 vs 2010 Regence MedAdvantage benefit comparisons
Copayment and coinsurance changes listed in red**

Benefit Element	2009 Regence MedAdvantage Classic		2010 Regence MedAdvantage Classic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	\$0	\$50 Applies to Medicare covered services only	\$50 Applies to Medicare covered services only
Out-of-Pocket Maximum	\$1,500	\$3,000	\$2,500	\$4,000
Inpatient Hospital (unlimited days)	\$100 per day, up to a maximum of \$500 per benefit period, no limit to the number of days	\$200/day for days 1-5; maximum of \$1000; no limit to the number of days	\$175 per day, up to a maximum of \$875 per benefit period, no limit to the number of days	\$250 per day, up to a maximum of \$1,250 per benefit period, no limit to the number of days
Inpatient Mental Health Care	\$100 per day, up to a maximum of \$500, per benefit period; 190 day lifetime maximum	\$200/day for days 1-5; maximum of \$1000;-per benefit period, 190 day lifetime maximum	\$175 per day, up to a maximum of \$875 per benefit period, 190 day lifetime maximum	\$250 per day, up to a maximum of \$1,250 per benefit period, 190 day lifetime maximum
Skilled Nursing Facility (no 3-day hospital stay requirement)	No copay Days 1-100 (no benefits after 100 days)	\$25 per day Days 1-100 (no benefits after 100 days)	\$10 per day Days 1-100 (no benefits after 100 days)	\$30 per day Days 1-100 (no benefits after 100 days)
Home Health Care	No copay	20% coinsurance	10% coinsurance	20% coinsurance
Doctor / Specialist Office Visit	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Chiropractic Services (manual manipulation to correct subluxation)	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Podiatry Services	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Mental Health Care	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Substance Abuse Care	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Services / Surgery	No copay	\$100	\$200 copay	\$300 copay
Ambulance Services	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Worldwide Emergency Care	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)
Urgently Needed Care (billed/coded from Urgent Care Facility only)	\$25 each visit	\$25 each visit	\$25 each visit	\$35 each visit
Outpatient Rehabilitation Services	\$10 each visit	\$25 each visit	\$25 each visit	\$35 each visit

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Benefit Element	2009 Regence MedAdvantage Classic		2010 Regence MedAdvantage Classic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DME and related supplies	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
Prosthetic Devices and related supplies	10% coinsurance	20% coinsurance	10% coinsurance	20% coinsurance
Diabetes Self-Monitoring Training and Supplies	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2
Lab Services	No copay	No copay	No copay	No copay
Diagnostic Tests and Radiology	No copay	No copay	10% coinsurance	20% coinsurance
Bone Mass Measurement	No copay	No copay	No copay	No copay
Colorectal Screening Exams	No copay	No copay	No copay	No copay
Immunizations (Medicare-covered)	No copay	No copay	No copay	No copay
Mammograms	No copay	No copay	No copay	No copay
Pap Smears/Pelvic Exams	No copay	No copay	No copay	No copay
Prostate Cancer Screening Exams	No copay	No copay	No copay	No copay
Dental Services	Medicare covered dental care - \$10 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$35 copay; Preventive services, no copay, up to \$500
Hearing Services	\$10 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams	\$35 copay for diagnostic hearing exams
Routine Vision Exams	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Vision Exams related to diagnosis or disease	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Vision hardware	Scheduled limit for eyewear (\$100 every 2 years)	Scheduled limit for eyewear (\$100 every 2 years)	\$100 scheduled limit for eyewear every 2 years	\$100 scheduled limit for eyewear every 2 years
Routine Physical Exam	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Welcome to Medicare physical	\$10 copay	\$25 copay	\$25 copay	\$35 copay
Dialysis	No copay	No copay	10% coinsurance	10% coinsurance

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Benefit Element	2009 Regence MedAdvantage and Regence MedAdvantage Enhanced		2010 Regence MedAdvantage and Regence MedAdvantage Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum	\$1,500	\$3,000	\$2,000	\$3,500
Inpatient Hospital (unlimited days)	\$100 per day, up to a maximum of \$500 per benefit period, no limit to the number of days	\$200/day for days 1-5; maximum of \$1000; no limit to the number of days	\$125 per day, up to a maximum of \$625 per benefit period, no limit to the number of days	\$225 per day, up to a maximum of \$1,125 per benefit period; no limit to the number of days
Inpatient Mental Health Care	\$100 per day, up to a maximum of \$500, per benefit period; 190 day lifetime maximum	\$200/day for days 1-5; maximum of \$1000;-per benefit period, 190 day lifetime maximum	\$125 per day, up to a maximum of \$625 per benefit period, 190 day lifetime maximum	\$225 per day, up to a maximum of \$1,125 per benefit period, 190 day lifetime maximum
Skilled Nursing Facility (no 3-day hospital stay requirement)	No copay Days 1-100 (no benefits after 100 days)	\$25 per day Days 1-100 (no benefits after 100 days)	No copay Days 1-100 (no benefits after 100 days)	\$25 per day Days 1-100 (no benefits after 100 days)
Home Health Care	No copay	20% coinsurance	No copay	10% coinsurance
Doctor / Specialist Office Visit	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Chiropractic Services (manual manipulation to correct subluxation)	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Podiatry Services	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Outpatient Mental Health Care	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Outpatient Substance Abuse Care	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Outpatient Services / Surgery	No copay	\$100	\$100 copay	\$200 copay
Ambulance Services	\$100 copay	\$100 copay	\$100 copay	\$100 copay
Worldwide Emergency Care	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)	\$50 copay (waived if admitted within 48 hours)
Urgently Needed Care (billed/coded from Urgent Care Facility only)	\$25 each visit	\$25 each visit	\$10 each visit	\$25 each visit
Outpatient Rehabilitation Services	\$10 each visit	\$25 each visit	\$10 each visit	\$25 each visit

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	In-Network	Out-of-Network	In-Network	Out-of-Network
DME and related supplies	10% coinsurance	20% coinsurance	No copay	10% coinsurance
Prosthetic Devices and related supplies	10% coinsurance	20% coinsurance	No copay	10% coinsurance
Diabetes Self-Monitoring Training and Supplies	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2	Part B - No copay, lancets, test strips & glucometer; Part D insulin & syringes - Tier 2
Lab Services	No copay	No copay	No copay	No copay
Diagnostic Tests and Radiology	No copay	No copay	No copay	10% coinsurance
Bone Mass Measurement	No copay	No copay	No copay	No copay
Colorectal Screening Exams	No copay	No copay	No copay	No copay
Immunizations (Medicare-covered)	No copay	No copay	No copay	No copay
Mammograms	No copay	No copay	No copay	No copay
Pap Smears/Pelvic Exams	No copay	No copay	No copay	No copay
Prostate Cancer Screening Exams	No copay	No copay	No copay	No copay
Dental Services	Medicare covered dental care - \$10 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$10 copay; Preventive services, no copay, up to \$500	Medicare covered dental care - \$25 copay; Preventive services, no copay, up to \$500
Hearing Services	\$10 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams	\$10 copay for diagnostic hearing exams	\$25 copay for diagnostic hearing exams
Routine Vision Exams	\$10 copay	\$25 copay	\$10 copay	\$25 copay
Vision Exams related to diagnosis or disease	\$10 copay	\$25 copay	\$10 copay	\$25 copay
Vision hardware	Scheduled limit for eyewear (\$100 every 2 years)	Scheduled limit for eyewear (\$100 every 2 years)	\$200 scheduled limit for eyewear every 2 years	\$200 scheduled limit for eyewear every 2 years
Routine Physical Exam	\$10 copay	\$25 copay	\$10 copay	\$25 copay
Welcome to Medicare physical	\$10 copay	\$25 copay	\$10 copay	\$25 copay
Dialysis	No copay	No copay	No copay	No copay