2019 Regence Medicare Advantage Enrollment Packet

Thank you for your interest in applying for the Regence BlueCross BlueShield of Oregon Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Letter" from Regence BlueCross BlueShield of Oregon within 15 days of the application receipt.

Enrollment Packet – click links below to download and save documents

Star Rating: HMO / PPO
Apply Online
Download Application: MedAdvantage Basic / Metro / Non-Metro
Benefit Schedule: MedAdvantage Basic / Metro / Non-Metro
Provider Search
Pharmacy Search
Formulary

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613.
Our website: https://medicare-oregon.com/

Y0062_MULTIPLAN_CDA INSURANCE Oregon 2019

Regence

JANUARY 1 – DECEMBER 31, 2019

Summary of Benefits

for the service area of Clackamas, Lane, Multnomah and Washington counties

Regence **BlueAdvantage HMO**

Regence **BlueAdvantage HMO Plus**

Regence **MedAdvantage + Rx Primary** (PPO)

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

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

This document is available electronically and may be available in other formats.

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal. This information is not a complete description of benefits. Call 1-888-369-3171 (TTY: 711) for more information.

Y0062_OR1-2019SB_M

Are you eligible?

To join a Regence Medicare Advantage HMO or PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

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.

The benefit information provided is a summary of what we cover and what you pay**. It does not list every service that we cover or list every limitation or exclusion.** A complete list of services we cover is found in our Evidence of Coverage (EOC). You can view our plan's EOC on our website at **regence.com/medicare** or request one through Customer Service.

For more information

Please call us at the phone number below or visit us at **regence.com/medicare**.

Prospective members call
1-888-369-3171 (TTY: 711)

Current HMO members call
1-855-522-8896 (TTY: 711)

Current PPO members call
1-800-541-8981 (TTY: 711)

Hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday (October 1 through March 31, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week).

Using in-network providers

HMO plans

Regence BlueAdvantage HMO and **Regence BlueAdvantage HMO Plus** plans have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services. You must choose a primary care provider (PCP) when you sign up for one of our HMO plans. You can see our plan's provider directory (including PCPs accepting new patients) and pharmacy directory at our website, **regence.com/medicare.**

PPO plans

Regence MedAdvantage + Rx Primary (PPO), Regence MedAdvantage + Rx Classic (PPO) and **Regence MedAdvantage + Rx Enhanced (PPO)** have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, you may pay more for these services. You can see our plan's provider directory and pharmacy directory at our website, **regence.com/medicare.**

Using out-of-network providers

HMO plans

Out-of network/non-contracted providers are generally not covered under your plan, except in urgent/emergent situations, or if there are no in-network providers that can provide the service needed and your PCP has obtained a prior authorization. Please call Customer Service for complete information.

PPO plans

Out-of-network/non-contracted providers are under no obligation to treat Regence members, except in emergency situations. If you receive care from an out-of-network/non-contracted provider, we will pay for the same services we cover in network, as long as the services are medically necessary. Please call our Customer Service number or see Chapter 4, section 1 of your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Regence
BlueAdvantage HMO

Regence
BlueAdvantage HMO Plus

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Service area	**Clackamas, Multnomah and Washington counties**	

Premium, deductible and out-of-pocket limits

Monthly plan premium	$0	$35
	You must continue to pay your Medicare Part B premiums.	
Deductible		
Medical	$0	$0
Prescription	$200 (waived for Tiers 1 and 2)	$0
Maximum out-of-pocket responsibility (Does not include prescription drugs)	$5,500 annually	$4,900 annually
	The most you pay for copays, coinsurance and other costs for Medicare-covered Part A and Part B medical services for the year. Some services do not apply to the maximum out-of-pocket.	

Medical and hospital benefits

Inpatient hospital coverage[1]	Days 1 through 4: $430 copay per day Days 5 and beyond: $0 copay per day	Days 1 through 4: $375 copay per day Days 5 and beyond: $0 copay per day
Outpatient hospital coverage		
Ambulatory surgical center services[1]		
-For wound care	$40 copay	$35 copay
-For all other services	$300 copay	$275 copay
Outpatient hospital services[1]		
-For wound care	$40 copay	$35 copay
-For all other services	20% coinsurance	20% coinsurance

__1-__ Services may require prior authorization. __2-__ Services may require a referral from your doctor.
__3-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
__4-__ Services do not apply to the out-of-pocket maximum.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**

Medical and hospital benefits (cont.)

Doctor visits		
Primary care provider[3]	$5 copay	$0 copay
Specialist[2,3]	$40 copay	$35 copay
Preventive care	$0 copay	$0 copay

The Medicare-covered preventive services listed below are covered under this benefit. Any additional preventive services approved by Medicare during the contract year will be covered.

- Annual Wellness Visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening (colonoscopy, fecal occult blood test, or flexible sigmoidoscopy)
- Depression screening
- Diabetes screening
- Glaucoma screening
- HIV screening
- LDCT (screening for lung cancer with low-dose computed tomography)
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy
- Prostate cancer screening (PSA)
- Sexually transmitted infections screening and counseling
- Some immunizations (including flu, hepatitis B, and pneumococcal shots)
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- “Welcome to Medicare” preventive visit (one-time)

__1-__ Services may require prior authorization. __2-__ Services may require a referral from your doctor.
__3-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
__4-__ Services do not apply to the out-of-pocket maximum.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Emergency care	$90 copay	$90 copay
	Waived if admitted to the hospital within 48 hours for the same condition	
Urgently needed services	$40 copay	$35 copay
Diagnostic services/labs/imaging		
Diagnostic radiology (MRI, CAT, etc.)[1]	20% coinsurance	20% coinsurance
Lab services[1]	$5 copay	$5 copay
Diagnostic tests and procedures[1]	$5 copay	$5 copay
Outpatient X-rays	$5 copay	$5 copay
Hearing services		
Medical hearing exam[2,3]	$40 copay	$35 copay
Dental services		
Medical dental services[2,3]	$40 copay	$35 copay
Preventive dental services[4]	**Not covered**; see the Optional Supplemental Benefits section of this book for preventive dental options available for an additional premium	$0 copay Services covered with in-network dental providers **only** and are limited to: 1 full-mouth X-ray every 3 years 2 preventive exams every year 2 cleanings every year 2 (sets) bitewings every year

__1-__ Services may require prior authorization. __2-__ Services may require a referral from your doctor. __3-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __4-__ Services do not apply to the out-of-pocket maximum.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Vision services		
Medical vision services[2,3]	$0 copay	$0 copay
Routine vision exam[4]	**Not covered**; see the Optional Supplemental Benefits section of this book for routine vision exam options available for an additional premium	$0 copay Services covered with VSP providers **only** and limited to 1 routine vision exam every year
Routine vision hardware[4]	**Not covered**; see the Optional Supplemental Benefits section of this book for routine vision hardware options available for an additional premium	**Lenses:** $0 copay **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** $0 copay Services covered with VSP providers **only** and limited to: **Lenses:** 1 set of basic single vision, lined bifocal, lined trifocal or lenticular lenses every year **Frames:** 1 pair of frames up to the allowance every year **OR** **Contacts:** Single purchase of elective contact lenses up to the allowance (includes fittings) covered every year

__1-__ Services may require prior authorization. __2-__ Services may require a referral from your doctor. __3-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __4-__ Services do not apply to the out-of-pocket maximum.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Mental health services		
Inpatient[1]	Days 1 through 4: $375 copay per day Days 5 through 190: $0 copay per day	Days 1 through 4: $375 copay per day Days 5 through 190: $0 copay per day
Outpatient[1,3] (Individual and group therapy)	$5 copay from a PCP $40 copay from a specialist	$0 copay from a PCP $35 copay from a specialist
Skilled nursing facility[1] (Up to 100 days per benefit period are covered)	Days 1 through 20: $0 copay per day Days 21 through 100: $167 copay per day	Days 1 through 20: $0 copay per day Days 21 through 100: $167 copay per day
Physical therapy[1,3] (Includes occupational therapy and speech language therapy)	$40 copay	$35 copay
Ambulance[1]	$275 copay per one-way transport	$275 copay per one-way transport
Transportation	Not covered	Not covered
Medicare Part B drugs[1]	20% coinsurance	20% coinsurance

Regence HMO plans cover Part B drugs such as chemotherapy and other drugs administered by your provider. In addition, we cover Part D drugs through the prescription benefit. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **regence.com/medicare**.

1- *Services may require prior authorization.* ***2-*** *Services may require a referral from your doctor.*
3- *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.*
4- *Services do not apply to the out-of-pocket maximum.*

Medicare Part D prescription drugs—initial coverage phase cost-sharing

Regence **BlueAdvantage HMO**

You pay a **$200** Part D prescription drug deductible annually **(waived for Tiers 1 and 2)**

Tier	**30-day supply** Preferred retail and mail order	**30-day supply** Standard retail, out-of-network* and LTC** facility	**90-day supply** Preferred retail and mail order	**90-day supply** Standard retail
1 Preferred generic	$3 copay	$10 copay	$6 copay	$20 copay
2 Generic	$12 copay	$19 copay	$24 copay	$38 copay
3 Preferred brand	$40 copay	$47 copay	$100 copay	$117.50 copay
4 Non-preferred drug	40% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
5 Specialty	29% coinsurance	29% coinsurance	Not available	Not available

Regence **BlueAdvantage HMO Plus**

This plan **does not** have a Part D prescription drug deductible

Tier	**30-day supply** Preferred retail and mail order	**30-day supply** Standard retail*, out-of-network and LTC** facility	**90-day supply** Preferred retail and mail order	**90-day supply** Standard retail
1 Preferred generic	$3 copay	$10 copay	$6 copay	$20 copay
2 Generic	$8 copay	$15 copay	$16 copay	$30 copay
3 Preferred brand	$40 copay	$47 copay	$100 copay	$117.50 copay
4 Non-preferred drug	40% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
5 Specialty	33% coinsurance	33% coinsurance	Not available	Not available

For more information about prescription coverage see page 34.

**You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy.*
***Long-term care facility (31-day supply).*

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Other benefits		
Acupuncture[4]	Not covered	$20 copay Limited to 18 visits every year, combined with naturopathy and additional chiropractic services
Annual physical exam	$0 copay Limited to once every year and in addition to the Medicare Annual Wellness Visit	$0 copay
Chiropractic care		
Medicare-covered	$20 copay Limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	$20 copay
Additional chiropractic coverage[4]	Not covered	$20 copay Limited to 18 visits every year, combined with acupuncture and naturopathy
Naturopathy[4]	Not covered	$20 copay Limited to 18 visits every year, combined with acupuncture and additional chiropractic services
Virtual visits	$5 copay You can contact MDLIVE® or a primary care physician (if offered) by phone and/or video chat	$0 copay

1- *Services may require prior authorization.* ***2-*** *Services may require a referral from your doctor.*
3- *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.*
4- *Services do not apply to the out-of-pocket maximum.*

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Optional supplemental benefits— dental, vision and hearing benefits for your plan		
Monthly premium	$20 In addition to your monthly plan and Part B premiums	$28
Maximum out-of-pocket responsibility	Costs for optional supplemental benefits do not apply to the maximum out-of-pocket	
Dental services		
Preventive dental services	$0 copay Services covered with in-network dental providers **only** and limited to: 1 full-mouth X-ray every 3 years 2 preventive exams every year 2 cleanings every year 2 (sets) bitewings every year	Included in standard medical benefits
Comprehensive dental services	Not covered	50% coinsurance Services covered with in-network dental providers **only** and limited to: 2 problem-focused exams and 2 intraoral-periapical films every year Restorations, endodontics, periodontics, oral surgery, crowns, dentures, partials, bridges and implants, limited to specific dental codes (exclusions apply) $1,000 benefit limit per calendar year (services above the limit are your responsibility)
Vision services		
Routine vision exam	$0 copay Services covered with VSP providers **only** and limited to 1 routine vision exam every year	Included in standard medical benefits

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Optional supplemental benefits— dental, vision and hearing benefits for your plan (cont.)		
Vision services (cont.)		
Routine vision hardware	**Lenses:** $0 copay **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** $0 copay Services covered with VSP providers **only** and limited to: **Lenses:** 1 set of basic single vision, lined bifocal, lined trifocal or lenticular lenses every year **Frames:** 1 pair of frames up to the allowance every year **OR** **Contacts:** Single purchase of elective contact lenses up to the allowance (includes fittings) covered every year	Included in standard medical benefits
Hearing services		
Routine hearing exam	$45 copay	$45 copay
	Services covered with TruHearing providers **only** and limited to 1 routine hearing exam every year	
Hearing aids	$699 copay for each TruHearing Advanced hearing aid $999 copay for each TruHearing Premium hearing aid Services covered with TruHearing providers **only** and limited to 1 hearing aid per ear, per year; coverage only for aids listed	

Regence **MedAdvantage + Rx Primary** (PPO)

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

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

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Service area	**Clackamas, Lane, Multnomah and Washington counties**		
Premium, deductible and out-of-pocket limits			
Monthly plan premium	$19	$48	$175
	You must continue to pay your Medicare Part B premiums.		
Deductible			
Medical	$0	$0	$0
Prescription	$300 (waived for Tiers 1 and 2)	$250 (waived for Tiers 1 and 2)	$0
Maximum out-of-pocket responsibility (Does not include prescription drugs)	**In-network providers:** $6,700 annually **Combined in- and out-of-network providers:** $10,000 annually	**In-network providers:** $6,000 annually **Combined in- and out-of-network providers:** $10,000 annually	**In-network providers:** $5,000 annually **Combined in- and out-of-network providers:** $8,300 annually
	This is the most you pay for copays, coinsurance and other costs for Medicare-covered Part A and Part B medical services for the year. Some services do not apply to the maximum out-of-pocket.		
Medical and hospital benefits			
Inpatient hospital coverage[1]	**In-network:** Days 1 through 4: $400 copay per day Days 5 and beyond: $0 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day	**In-network:** Days 1 through 4: $395 copay per day Days 5 and beyond: $0 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day	**In-network:** Days 1 through 5: $315 copay per day Days 6 and beyond: $0 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Outpatient hospital coverage			
Ambulatory surgical center services[1]			
-For wound care -For all other services	**In-network:** $45 copay 15% coinsurance	**In-network:** $40 copay 15% coinsurance	**In-network:** $25 copay 15% coinsurance
-All outpatient services	**Out-of-network:** 50% coinsurance	**Out-of-network:** 50% coinsurance	**Out-of-network:** 50% coinsurance
Outpatient hospital services[1]			
-For wound care -For all other services	**In-network:** $45 copay 20% coinsurance	**In-network:** $40 copay 20% coinsurance	**In-network:** $25 copay 20% coinsurance
-All outpatient services	**Out-of-network:** 50% coinsurance	**Out-of-network:** 50% coinsurance	**Out-of-network:** 50% coinsurance
Doctor visits			
Primary care provider[2]	**In-network:** $15 copay **Out-of-network:** 50% coinsurance	**In-network:** $10 copay **Out-of-network:** 50% coinsurance	**In-network:** $5 copay **Out-of-network:** 50% coinsurance
Specialist[2]	**In-network:** $45 copay **Out-of-network:** 50% coinsurance	**In-network:** $40 copay **Out-of-network:** 50% coinsurance	**In-network:** $25 copay **Out-of-network:** 50% coinsurance

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Preventive care	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance

The Medicare-covered preventive services listed below are covered under this benefit. Any additional preventive services approved by Medicare during the contract year will be covered.

- Annual Wellness Visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening (colonoscopy, fecal occult blood test, or flexible sigmoidoscopy)
- Depression screening
- Diabetes screening
- Glaucoma screening
- HIV screening
- LDCT (screening for lung cancer with low-dose computed tomography)
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP) ($0 out of network)
- Obesity screening and therapy
- Prostate cancer screening (PSA)
- Sexually transmitted infections screening and counseling
- Some immunizations (including flu, hepatitis B, and pneumococcal shots)
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- “Welcome to Medicare” preventive visit (one-time)

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Emergency care	**In- and out-of-network:** $90 copay	**In- and out-of-network:** $90 copay	**In- and out-of-network:** $90 copay
	Waived if admitted to the hospital within 48 hours for the same condition		
Urgently needed services	**In- and out-of-network:** $45 copay	**In- and out-of-network:** $40 copay	**In- and out-of-network:** $25 copay
Diagnostic services/labs/imaging			
Diagnostic radiology (MRI, CAT, etc.)[1]	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance
Lab services[1]	**In-network:** $20 copay **Out-of-network:** 50% coinsurance	**In-network:** $10 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
Diagnostic tests and procedures[1]	**In-network:** $20 copay **Out-of-network:** 50% coinsurance	**In-network:** $10 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
Outpatient X-rays	**In-network:** $20 copay **Out-of-network:** 50% coinsurance	**In-network:** $10 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Hearing services			
Medical hearing exam[2]	**In-network:** $45 copay **Out-of-network:** 50% coinsurance	**In-network:** $40 copay **Out-of-network:** 50% coinsurance	**In-network:** $25 copay **Out-of-network:** 50% coinsurance
Routine hearing exam[3]	**Not covered**; see the Optional Supplemental Benefits Section of this book for routine hearing exam options available for an additional premium	**Not covered**; see the Optional Supplemental Benefits Section of this book for routine hearing exam options available for an additional premium	**In-network** (TruHearing providers only): $45 copay **Out-of-network:** $150 copay Service limited to 1 routine hearing exam every year
Hearing aids[3]	**Not covered**; see the Optional Supplemental Benefits Section of this book for hearing aid options available for an additional premium	**Not covered**; see the Optional Supplemental Benefits Section of this book for hearing aid options available for an additional premium	$599 copay for each TruHearing Advanced aid $899 copay for each TruHearing Premium aid Services covered with TruHearing providers **only** and limited to 1 hearing aid per ear, per year; coverage only for aids listed
Dental services			
Medical dental services[2]	**In-network:** $45 copay **Out-of-network:** 50% coinsurance	**In-network:** $40 copay **Out-of-network:** 50% coinsurance	**In-network:** $25 copay **Out-of-network:** 50% coinsurance

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Dental services (cont.)			
Preventive dental services[3]	**Not covered**; see the Optional Supplemental Benefits Section of this book for preventive dental options available for an additional premium	**In-network:** $0 copay **Out-of-network:** 50% coinsurance Preventive dental services limited to: 1 full-mouth X-ray every 3 years 2 preventive exams every year 2 cleanings every year 2 bitewings every year Out-of-network dental providers may bill you for any charges remaining over the allowed amount	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
Comprehensive dental services[3]	Not covered	**Not covered**; see the Optional Supplemental Benefits Section of this book for comprehensive dental options available for an additional premium	**In- and out-of-network:** 50% coinsurance Services limited to: 2 problem-focused exams and 2 intra-oral-periapical films every year Restorations, endodontics, periodontics, oral surgery, crowns, dentures, partials, bridges and implants, limited to specific dental codes (exclusions apply) $1,000 benefit limit per calendar year (services above the limit are your responsibility); out-of-network dental providers may bill you for any charges remaining over the allowed amount

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Vision services			
Medical vision services[2]	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
Routine vision exam[3]	**Not covered**; see the Optional Supplemental Benefits Section of this book for routine vision exam options available for an additional premium	**In-network** (VSP providers only): $0 copay **Out-of-network:** 50% of the billed charge Services limited to 1 routine vision exam every year	**In-network** (VSP providers only): $0 copay **Out-of-network:** 50% of the billed charge
Routine vision hardware[3]	**Not covered**; see the Optional Supplemental Benefits Section of this book for routine vision hardware options available for an additional premium	**In-network** (VSP providers only): **Lenses:** $0 copay **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** $0 copay	**In-network** (VSP providers only): **Lenses:** $0 copay **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $150 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** $0 copay

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Vision services (cont.)			
Routine vision hardware[3] (cont.)		**Out-of-network:** **Lenses:** 50% of the billed charge **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** 50% of the billed charge	**Out-of-network:** **Lenses:** 50% of the billed charge **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $150 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** 50% of the billed charge
		In- and out-of-network services limited to: **Lenses:** 1 set of basic single vision, lined bifocal, lined trifocal or lenticular lenses every year **Frames:** 1 pair of frames up to the allowance every year **OR** **Contacts:** Single purchase of elective contact lenses up to the allowance (includes fittings) every year	

__1-__ Services may require prior authorization. __2-__ Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts. __3-__ Services do not apply to the out-of-pocket maximum.

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Mental health services			
Inpatient services[1]	**In-network:** Days 1 through 4: $400 copay per day Days 5 through 190: $0 copay per day **Out-of-network:** Days 1 through 190: 50% coinsurance per day	**In-network:** Days 1 through 4: $395 copay per day Days 5 through 190: $0 copay per day **Out-of-network:** Days 1 through 190: 50% coinsurance per day	**In-network:** Days 1 through 5: $315 copay per day Days 6 through 190: $0 copay per day **Out-of-network:** Days 1 through 190: 50% coinsurance per day
Outpatient services[1,2] (Individual and group therapy)	**In-network:** $15 copay from a PCP $40 copay from a specialist **Out-of-network:** 50% coinsurance	**In-network:** $10 copay from a PCP $40 copay from a specialist **Out-of-network:** 50% coinsurance	**In-network:** $5 copay from a PCP $25 copay from a specialist **Out-of-network:** 50% coinsurance
Skilled nursing facility[1] (Up to 100 days per benefit period are covered)	**In-network:** Days 1 through 20: $0 copay per day Days 21 through 100: $167 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day	**In-network:** Days 1 through 20: $0 copay per day Days 21 through 100: $160 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day	**In-network:** Days 1 through 20: $0 copay per day Days 21 through 100: $160 copay per day **Out-of-network:** Days 1 and beyond: 50% coinsurance per day
Physical therapy[1,2] (Includes physical therapy, occupational therapy and speech language therapy)	**In-network:** $40 copay **Out-of-network:** 50% coinsurance	**In-network:** $40 copay **Out-of-network:** 50% coinsurance	**In-network:** $25 copay **Out-of-network:** 50% coinsurance
Ambulance[1]	$275 copay per one-way transport	$275 copay per one-way transport	$250 copay per one-way transport
Transportation	Not covered	Not covered	Not covered

1- *Services may require prior authorization.* ***2-*** *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.* ***3-*** *Services do not apply to the out-of-pocket maximum.*

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Medical and hospital benefits (cont.)			
Medicare Part B drugs[1]	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance

Regence PPO plans cover Part B drugs such as chemotherapy and other drugs administered by your provider. In addition, we cover Part D drugs through the prescription benefit. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **regence.com/medicare**.

1- *Services may require prior authorization.* ***2-*** *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.* ***3-*** *Services do not apply to the out-of-pocket maximum.*

Medicare Part D prescription drugs—initial coverage phase cost sharing

Regence **MedAdvantage + Rx Primary** (PPO)

You pay a **$300** Part D prescription drug deductible annually **(waived for Tiers 1 and 2)**

Tier	**30-day supply** Preferred retail and mail order	**30-day supply** Standard retail, out-of-network* and LTC**facility	**90-day supply** Preferred retail and mail order	**90-day supply** Standard retail
1 Preferred generic	$3 copay	$10 copay	$6 copay	$20 copay
2 Generic	$13 copay	$20 copay	$26 copay	$40 copay
3 Preferred brand	$40 copay	$47 copay	$100 copay	$117.50 copay
4 Non-preferred drug	40% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
5 Specialty	27% coinsurance	27% coinsurance	Not available	Not available

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

You pay a **$250** Part D prescription drug deductible annually **(waived for Tiers 1 and 2)**

Tier	**30-day supply** Preferred retail and mail order	**30-day supply** Standard retail, out-of-network* and LTC** facility	**90-day supply** Preferred retail and mail order	**90-day supply** Standard retail
1 Preferred generic	$3 copay	$10 copay	$6 copay	$20 copay
2 Generic	$13 copay	$20 copay	$26 copay	$40 copay
3 Preferred brand	$40 copay	$47 copay	$100 copay	$117.50 copay
4 Non-preferred drug	40% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
5 Specialty	28% coinsurance	28% coinsurance	Not available	Not available

For more information about prescription coverage see page 34.

**You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy.*
***Long-term care facility (31-day supply).*

Medicare Part D prescription drugs—initial coverage phase cost sharing (cont.)

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

This plan **does not** have a Part D prescription drug deductible

Tier	**30-day supply** Preferred retail and mail order	**30-day supply** Standard retail, out-of-network* and LTC** facility	**90-day supply** Preferred retail and mail order	**90-day supply** Standard retail
1 Preferred generic	$3 copay	$10 copay	$6 copay	$20 copay
2 Generic	$8 copay	$15 copay	$16 copay	$30 copay
3 Preferred brand	$40 copay	$47 copay	$100 copay	$117.50 copay
4 Non-preferred drug	40% coinsurance	45% coinsurance	40% coinsurance	45% coinsurance
5 Specialty	33% coinsurance	33% coinsurance	Not available	Not available

For more information about prescription coverage see page 34.

**You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy.*
***Long-term care facility (31-day supply).*

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Other benefits			
Acupuncture[3]	Not covered	Not covered	**In-network:** $20 copay **Out-of-network:** 50% coinsurance Limited to 18 visits every year, combined with naturopathy and additional chiropractic services
Annual physical exam	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 copay **Out-of-network:** 50% coinsurance
	Limited to once every year and in addition to the Medicare Annual Wellness Visit		
Chiropractic care			
Medicare-covered	**In-network:** $20 copay **Out-of-network:** 50% coinsurance	**In-network:** $20 copay **Out-of-network:** 50% coinsurance	**In-network:** $20 copay **Out-of-network:** 50% coinsurance
	Limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)		
Additional chiropractic coverage[3]	Not covered	**In-network:** $20 copay **Out-of-network:** 50% coinsurance Limited to 18 visits every year	**In-network:** $20 copay **Out-of-network:** 50% coinsurance Limited to 18 visits every year, combined with acupuncture and naturopathy

1- *Services may require prior authorization.* ***2-*** *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.* ***3-*** *Services do not apply to the out-of-pocket maximum.*

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**	Regence **MedAdvantage + Rx Enhanced (PPO)**
Other benefits (cont.)			
Naturopathy[3]	Not covered	Not covered	**In-network:** $20 copay **Out-of-network:** 50% coinsurance Limited to 18 visits every year, combined with acupunture and additional chiropractic services
Virtual visits	**In-network:** $15 copay **Out-of-network:** 50% coinsurance	**In-network:** $10 copay **Out-of-network:** 50% coinsurance	**In-network:** $5 copay **Out-of-network:** 50% coinsurance
	You can contact MDLIVE® or a primary care physician (if offered) by phone and/or video chat		

1- *Services may require prior authorization.* ***2-*** *Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.* ***3-*** *Services do not apply to the out-of-pocket maximum.*

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**
Optional supplemental benefits— dental, vision and hearing benefits for your plan		
(Optional supplemental benefits are not available for the Regence MedAdvantage + Rx Enhanced plan as it already includes these benefits.)		
Monthly premium	$20	$28
	In addition to your monthly plan and Part B premiums	
Maximum out-of-pocket responsibility	Costs for optional supplemental benefits do not apply to the maximum out-of-pocket	
Dental services		
Preventive dental services	**In-network:** $0 copay **Out-of-network:** 50% coinsurance; out-of-network providers may bill you for any charges remaining over the allowed amount In- and out-of-network services are limited to: 1 full-mouth X-ray every 3 years 2 preventive exams every year 2 cleanings every year 2 (sets) bitewings every year	Included in standard medical benefits

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**
Optional supplemental benefits— dental, vision and hearing benefits for your plan (cont.)		
Dental services (cont.)		
Comprehensive dental services	Not covered	**In- and out-of-network:** 50% coinsurance Services limited to: 2 problem-focused exams and 2 intraoral-periapical films every year Restorations, endodontics, periodontics, oral surgery, crowns, dentures, partials, bridges and implants, limited to specific dental codes (exclusions apply) $1,000 benefit limit per calendar year (services above the limit are your responsibility); out-of-network dental providers may bill you for any charges remaining over the allowed amount

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**
Optional supplemental benefits— dental, vision and hearing benefits for your plan (cont.)		
Vision services		
Routine vision exam	**In-network** (VSP providers only): $0 copay **Out-of-network:** 50% of the billed charge Services limited to 1 routine vision exam every year	Included in standard medical benefits
Routine vision hardware	**In-network** (VSP providers only): **Lenses:** $0 copay **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** $0 copay	Included in standard medical benefits
	Out-of-network: **Lenses:** 50% of the billed charge **AND** **Frames** **OR** **Elective contact lenses (in lieu of eyeglasses):** Up to $100 allowance (you are responsible for amounts over the allowance) **Medically necessary contact lenses:** 50% of the billed charge	Included in standard medical benefits

	Regence **MedAdvantage + Rx Primary (PPO)**	Regence **MedAdvantage + Rx Classic (PPO)**
Optional supplemental benefits— dental, vision and hearing benefits for your plan (cont.)		
Vision services (cont,)		
Routine vision hardware (cont.)	**In-and out-of-network** services limited to: **Lenses:** 1 set of basic single vision, lined bifocal, lined trifocal or lenticular lenses every year **Frames:** 1 pair of frames up to the allowance every year **OR** **Contacts:** Single purchase of elective contact lenses up to the allowance (includes fittings) every year	
Hearing services		
Routine hearing exam	**In-network** (TruHearing providers only): $45 copay **Out-of-network:** $150 copay	**In-network** (TruHearing providers only): $45 copay **Out-of-network:** $150 copay
	Service limited to 1 routine hearing exam every year	
Hearing aids	$699 copay for each TruHearing Advanced hearing aid $999 copay for each TruHearing Premium hearing aid Services covered with TruHearing providers **only** and limited to 1 hearing aid per ear, per year; coverage only for aids listed	

Additional services for HMO and PPO plans

24-hour nurse line

Advice24 is a 24-hour nurse line staffed by nurses who can help you determine when, where and even if you should receive medical care when your normal doctor is unavailable. They are also able to provide self-care suggestions for minor injuries and illnesses, and help you find a nearby urgent care facility or emergency room. Call **1-800-267-6729**.

Urgent and emergency care when you travel

If you travel outside the United States, you can leave home without worrying about access to care if you need it (except for prescription drugs). The plan covers urgent care and medical emergencies anywhere in the world.

Visitor/traveler program (PPO plans only)

The Blue Medicare Advantage Network Sharing Program for PPO plans is available in select areas of 37 states and Puerto Rico: Alabama, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin. By using a participating provider while you travel the U.S. or Puerto Rico, you will enjoy the same in-network benefits for Medicare covered services as you would if you were still at home. You can search for a participating provider at **bcbs.com**.

No-cost gym memberships

The Silver&Fit® Exercise & Healthy Aging Program provides you access to fitness center/YMCA membership(s) through a broad network of participating locations or access to the Home Fitness program, with your choice of up to two Home Fitness Kits per calendar year. You can view Healthy Aging educational materials and a newsletter online or request it to be sent via mail. Access the program at **SilverandFit.com**.

Your personal well-being

With your wellness program, you can use our interactive tools, health trackers and wellness resources to take charge of your health and enjoy your life. Through your personalized dashboard on **regence.com/medicare** the online health assessment, digital self-guided programs, symptom checker and tracking for many apps and compatible devices are right at your fingertips. You will also find information about and links to basic health information, your benefits and other resources so you can be more empowered while reaching your life balance goals.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein.
Not all YMCAs participate in the network. Please check the searchable directory on the Silver&Fit website to see if your location participates in the program.

Additional services for HMO and PPO plans

Medications made easy

With MedSavvy® you are able to compare medications side by side for effectiveness and shop around for the lowest cost in your area based on your benefits, as well as other services. You can even ask a pharmacist if you still have questions for more personalized care. Access MedSavvy by signing in to your account on **regence.com/medicare**.

Virtual diabetes prevention

Retrofit is a diabetes prevention program offered in a virtual setting for members at risk of developing diabetes. The program delivers a personalized experience with expert coaches who provide practical training in making long-term dietary changes, increasing physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. Sign in on your secure account on **regence.com/medicare** to find out if you qualify.

Personalized Care Support (palliative care)

Get one-on-one support if you or your loved one is facing a serious or life-limiting condition. This program uses a team-based approach to coordinate care between medical providers and community resources so you get the support you need when you need it most.

Disease management

If you're living with a chronic condition, our disease management program can give you the tools and information you need to take an active role in your health.

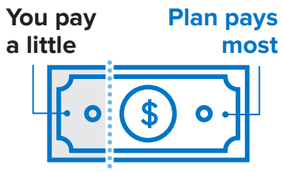
We'll help you understand how to manage your condition, support your doctor's care and help you improve your quality of life. We also give you checklists and information to help you figure out how you're doing and general information about your condition. You can get answers about your condition and its treatment over the phone from a registered nurse disease manager. They use guidelines based on research evidence to decide what education and support might work best for you.

Case management

Navigating the health care system can be a challenge, but when you're working through a health crisis, not knowing what to do can make things even harder. Regence Case Management can help. If you face a serious medical situation, you'll have access to one-on-one support at no extra cost. Our registered nurses and clinical behavioral health specialists will help you make sense of your health coverage and get the care you need.

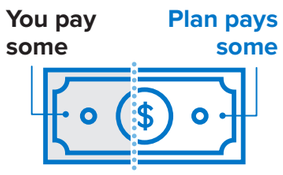
American Specialty Health Incorporated, MDLIVE, MedSavvy, Retrofit, TruHearing and VSP are separate and independent companies that do not provide Blue Cross and Blue Shield products or services, and are solely responsible for their products or services.

Additional prescription information for HMO and PPO plans



Initial coverage phase

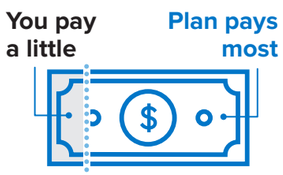
After you pay your annual deductible (if your plan has one), you pay a copay or coinsurance for each prescription you fill. Your plan pays the rest. You enter the coverage gap when the total amount you and your plan pay for covered drugs reaches $3,820.



Coverage gap phase

The coverage gap begins after the total yearly drug cost (what you have paid and what our plan has paid) reaches $3,820. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% percent of the plan's cost for covered generic drugs until your costs total $5,100—which is the end of the coverage gap. Not everyone will enter the coverage gap.

For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.



Catastrophic coverage phase

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of:

5% of the cost, or

$3.40 copay for generic (including brand name drugs treated as generic) and a $8.50 copay for all other drugs

Important information to know before you enroll

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-541-8981.**

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **regence.com/medicare** or call **1-800-541-8981** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ **For our HMO plans:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For our PPO plans:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

Notes

Notes

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

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ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

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