

# 2021 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](#)

Benefit Schedule: [Metro HMO-PPO](#) / [Non-Metro HMO](#) / [Non-Metro PPO](#)

Provider Search: [HMO](#) / [PPO](#)

[Pharmacy Search](#)

Formulary: [Primary PPO](#) / [Classic PPO](#) / [Enhanced PPO](#) / [HMO](#) / [HMO Plus](#)

### 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 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

### Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. ***If they are signed prior to October 15<sup>th</sup> they will be returned to you with a new application.*** If they are received after December 7<sup>th</sup>, 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...

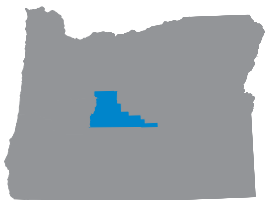
Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

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](mailto: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 2021



MEDICARE ADVANTAGE HMO PLANS

# 2021 Enrollment Guide

for residents of Deschutes County

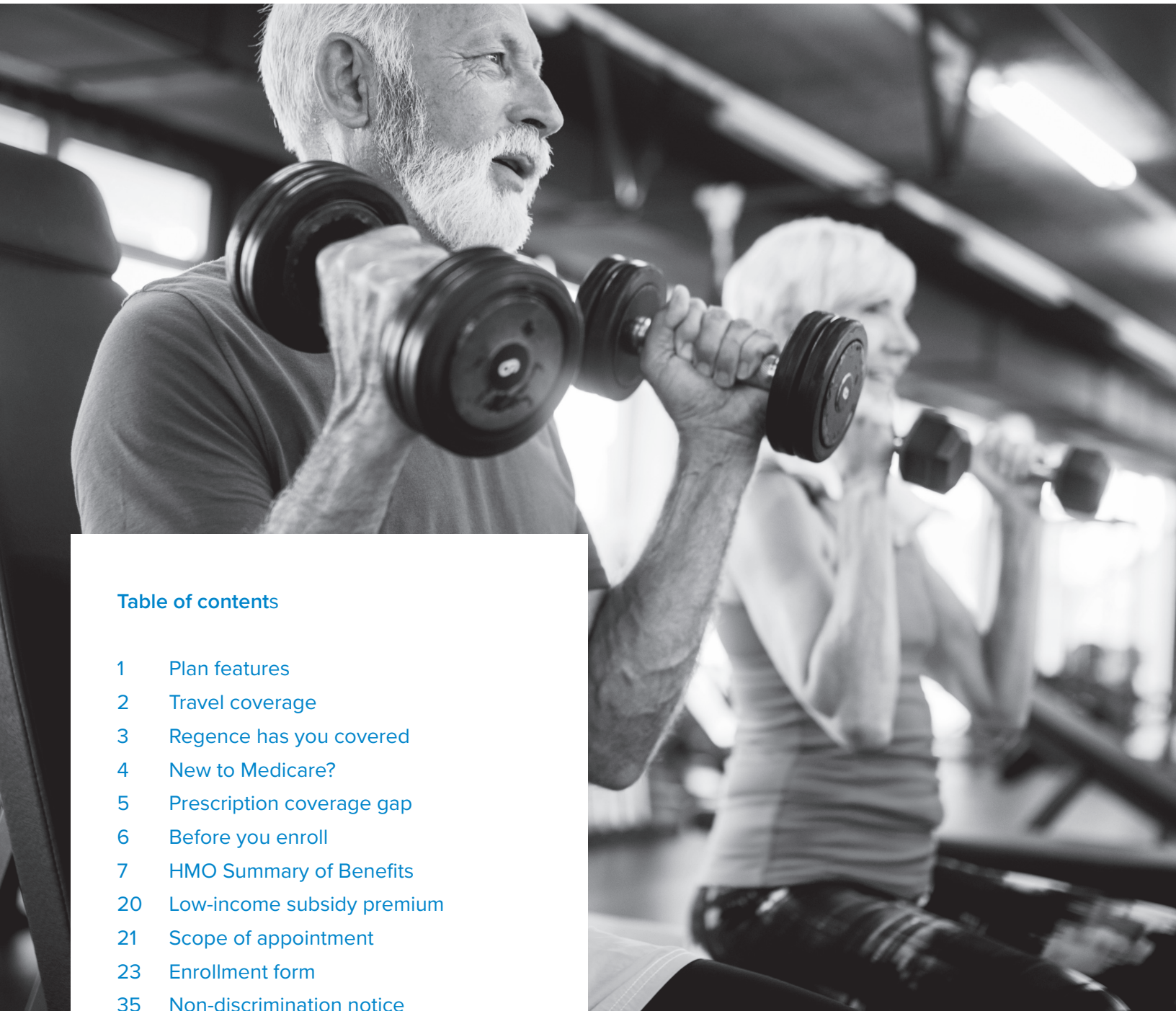


# Choose Blue. Choose Regence.

When you choose Regence you get the trust and support of a local health plan combined with the world-recognized provider acceptance and network coverage of a Blue Plan. We're opening doors to top hospitals, medical centers and providers so you can get high-quality care at a more affordable cost.

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- Insert: Star ratings



# You don't have to spend a lot to get a lot

Get all the extra benefits you need to stay healthy at no extra cost.



## Preventive dental

\$0 routine exams and X-rays  
\$0 cleanings and topical fluoride  
2 routine dental visits per year



## Comprehensive dental

\$0 diagnostic services with select plans\*  
Up to \$1,000 coverage for restorative care is available\*\*



## Routine vision exam and hardware

\$0 annual vision exam  
\$0 lenses and a yearly allowance for frames or contacts



## Routine hearing exam and hearing aids

\$0 routine hearing exam  
Coverage for up to 2 hearing aids



## Alternative care

Acupuncture, chiropractic, therapeutic massage and naturopathy benefits



## Regence Empower™

Participate in self-paced online health education programs, and track your activities and health goals



## Virtual doctor visits (telehealth)

Medical care and mental health visits are available by mobile app, video or phone



## Over-the-counter supplies

\$40 quarterly prepaid card available with select plans  
Use at participating retail locations or online at **NationsOTC.com**



## Silver&Fit® fitness program

\$0 basic fitness center membership  
**NEW** expanded home fitness options:  
Up to two Home Fitness Kits per year from 34 unique options  
One Stay Fit Kit per year with options that include yoga, strength training, or a complimentary Fitbit or Garmin fitness tracker  
Weekly coaching phone sessions



## Home safety and support

\$0 personal emergency response device (PERS) with free monthly monitoring  
\$0 virtual companionship services with phone visits, grocery drop off, and more\*\*  
\$0 meal delivery for post-hospital stay or chronic condition nutritional support\*\*

\*Optional comprehensive dental coverage can be added for an additional monthly premium. See the Summary of Benefits for more details about our plan's supplemental and optional benefits.  
\*\*Eligibility criteria applies.





## Coverage that travels with you

Our HMO plans cover urgent and emergency medical care in 190+ countries around the world. You won't pay any more than you would at home. Learn more at [bcbsglobalcore.com](https://www.bcbsglobalcore.com).



## Be ready for whatever life brings your way

Life can be unpredictable, but your Regence Medicare Advantage plan has you covered now and in the future.

### Need your annual checkup?

Your plan includes a no-cost annual physical exam, plus all your Medicare-covered preventive services and immunizations, so it's easy to maintain your good health.

### Can't get to the doctor?

Virtual doctor visits (telehealth) are a convenient alternative to an office visit. Speak to a board-certified doctor or psychiatrist in the comfort of your own home. If needed, they'll send prescriptions directly to your pharmacy.

### Want to stay safe and healthy at home?

Feel more confident with a no-cost medical alert device that includes automatic fall detection and provides 24-hour emergency response at the push of a button. Our fitness benefit now includes weekly health coaching and expanded home fitness options when going to the gym isn't feasible. You may also be eligible for virtual companionship services for phone visits, grocery and pharmacy pick-up/delivery, technology assistance and more.

### Need easier access to your medications?

Filling a three-month supply of your medication saves you a trip to the pharmacy and may save you money. Or avoid the pharmacy and sign up for home-delivery with free standard shipping anywhere in the United States.

### Unsure of what kind of care you need?

Our confidential nurse line gives you 24/7 access to a medical professional to discuss symptoms, get home care options or determine if you need to see a doctor.

### Managing a chronic condition?

Our specialized care management programs offer one-on-one health support, including help coordinating supplies, prescriptions, caregiver support and more. You may also qualify for nutritional support with meal delivery services at no cost.

### Financial circumstances impacting your life or health?

You may qualify for help with medical costs, heating bills, meal programs or more. Compassionate advocates can help if you're eligible for lower premium and prescription drug costs. They can also enroll you in social or community-based programs.

### Are you or a family member facing a serious illness?

Palliative care provides no-cost, patient-centered support for people with serious illness or injury. Services include medical care coordination, pain/symptom management, counseling services and more.



# New to Medicare?

Medicare can be confusing. Below are answers to some common questions.

## How can I find out if my doctors and prescription drugs are covered?

Make a list of your doctors and prescriptions and call us at **1-888-REGENCE** (1-888-734-3623). Or visit [regence.com/medicare](https://www.regence.com/medicare) to search our list of providers, pharmacies and covered drugs.

## I have VA benefits. Can I sign up for Regence Medicare Advantage?

Yes. Medicare Advantage doesn't replace VA benefits, and you can still use VA medical and prescription benefits. But Medicare Advantage offers extra benefits, more provider choices and worldwide travel coverage for urgent and emergency care.

## Can I have a Medicare Advantage plan and a separate Part D plan?

No. Federal regulations don't allow you to enroll in a separate Part D prescription drug plan in addition to a Medicare Advantage plan. If you want prescription drug coverage, choose a Medicare Advantage plan with prescription benefits.

## What if I work past age 65?

If you have coverage through your employer, you may be able to delay Medicare until you retire. However, if your employer has fewer than 20 employees, you may need to sign up for Medicare at 65 even if you still work. Consult your employer's benefit manager or your Social Security office for more information.

## Do your plans cover me when I travel?

Yes. All Regence Medicare Advantage plans cover urgent and emergency care anywhere in the world, except for Part D prescription drugs.

## How can I get help with Medicare costs?

The Low-Income Subsidy program (also called "Extra Help") helps pay all or most of your monthly plan premium, yearly deductibles and prescription costs. Contact your Social Security office for more information.

## Does it cost more to enroll with an agent?

No. There is never an extra cost or obligation if you enroll with an agent or broker. Agents are trained insurance professionals who can help you decide which plan is the best fit for you.

## When will my coverage be effective?

If you're new to Medicare, we'll notify you of your effective date as soon as Medicare verifies your eligibility. If you're switching plans during the Annual Enrollment Period (Oct. 15 - Dec. 7), your coverage will take effect on Jan. 1 of the following year.

## Why choose an HMO plan?

HMO plans provide low-cost health coverage and the confidence of having your primary care doctor manage your care within a local provider network. You must choose a primary care provider (PCP) from the plan's provider network when you enroll in an HMO plan.

# Prescription costs in the coverage gap

## Deductible

### Meet your plan's prescription deductible

You first need to meet your plan's annual prescription deductible. Your deductible amount resets every calendar year on Jan. 1. There is no deductible for generic medications on Tiers 1 and 2.

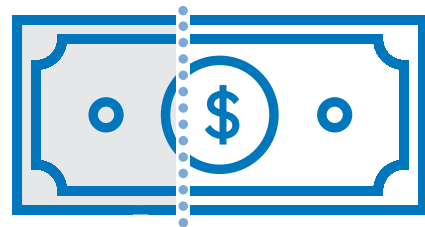


Pay the plan's prescription deductible (\$0 for Tiers 1 and 2)

## Initial coverage

### Pay a copay or coinsurance for each fill until total spent by you and plan reaches \$4,130

After you meet your deductible, you pay a copay or coinsurance for each prescription until the amount you and your plan spend on prescriptions reaches the initial coverage limit. Then you enter the coverage gap. Not everyone will enter the coverage gap.

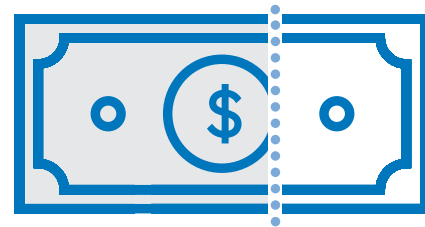


Pay a copay or coinsurance until prescription costs reach \$4,130

## Coverage gap

### Pay 25% of negotiated price for generic and brand-name drugs until your prescription spending reaches \$6,550

After the initial coverage limit is met, you enter the coverage gap. You pay 25% of your plan's negotiated price for generic and brand-name drugs until your spending on prescription drugs reaches the total out-of-pocket threshold. Then you enter catastrophic coverage.



Pay 25% until your total spend on prescriptions reaches \$6,550

## Catastrophic coverage

### Pay the greater of 5% or \$3.70 for generic drugs; pay the greater of 5% or \$9.20 for brand-name drugs

When you enter catastrophic coverage, you pay only a small amount for your covered drugs for the rest of the year. Your plan pays the rest.



Pay 5% or \$3.70 for generics and 5% or \$9.20 for brand-name drugs



## Before you enroll



### Look up your doctors and medications

Visit [regence.com/medicare](https://www.regence.com/medicare) and use our search tools to make sure your doctor is in our provider network and your medications are covered under our formulary (list of covered prescription drugs).

We recommend using in-network providers to help you save money. You will always get the highest level of coverage and lowest costs when you see an in-network provider. HMO plans do not cover services from out-of-network providers except in urgent or emergency care situations.



### Join a webinar

Attend a free, no-obligation informational webinar where you can find out more about Medicare, ask questions and learn more about your Regence Medicare plan options. Visit us at [regence.com/medicare](https://www.regence.com/medicare) to register for webinars and events, watch informational videos and find other helpful resources.



### Or let us do the work for you

Regence Medicare plan advisors are ready to help you choose a plan, find a doctor or look up your medications. You can even skip the paperwork and let us complete your enrollment over the phone. Simply call **1-844-REGENCE** (734-3623) (TTY: 711), 8 a.m. to 5 p.m., Pacific time, Monday through Friday.



### Ready to enroll?

1. Fill out and sign the enrollment form included in this guide.
2. Verify that the information from your Medicare card is listed correctly on your enrollment application. Or make a copy of your Medicare card and attach it to your enrollment application.
3. Return your completed and signed enrollment form in the enclosed postage-paid return envelope. Do not send any payment with your enrollment application.

Or visit [regence.com/go/shop](https://www.regence.com/go/shop) to choose a plan and enroll online.



MEDICARE ADVANTAGE HMO PLANS

# 2021 Summary of Benefits

for residents of Deschutes County

The information listed is a summary of what we cover and **what you pay**. It does not list every service, coverage limitation or exclusion. You must choose a primary care provider (PCP) from the plan's provider network when you enroll in an HMO plan.

|                                                       | Regence <b>BlueAdvantage</b><br><b>HMO</b>  | Regence <b>BlueAdvantage</b><br><b>HMO Plus</b> |
|-------------------------------------------------------|---------------------------------------------|-------------------------------------------------|
| <b>Plan number</b>                                    | H6237-007-003                               | H6237-008-003                                   |
| <b>Monthly plan premium</b>                           | \$49                                        | \$88                                            |
| <b>Annual deductible</b>                              |                                             |                                                 |
| Medical                                               | \$0                                         | \$0                                             |
| Prescription                                          | \$0 (Tiers 1,2)<br>\$200 (Tiers 3,4,5)      | \$0 (Tiers 1,2)<br>\$100 (Tiers 3,4,5)          |
| <b>Maximum out-of-pocket responsibility</b>           | \$5,500                                     | \$4,900                                         |
|                                                       | <b>In-network</b>                           | <b>In-network</b>                               |
| <b>Inpatient hospital coverage<sup>1,3</sup></b>      | Days 1-4: \$430 / day<br>Days 5+: \$0 / day | Days 1-4: \$375 / day<br>Days 5+: \$0 / day     |
| <b>Ambulatory surgery center services<sup>1</sup></b> |                                             |                                                 |
| For wound care                                        | \$40                                        | \$35                                            |
| For all other services                                | \$300                                       | \$275                                           |
| <b>Outpatient hospital services<sup>1</sup></b>       |                                             |                                                 |
| For wound care                                        | \$40                                        | \$35                                            |
| For observation                                       | \$90                                        | \$90                                            |
| For all other services                                | \$350                                       | \$300                                           |
| <b>Doctor visits</b>                                  |                                             |                                                 |
| Primary care provider                                 | \$0                                         | \$0                                             |
| Specialist <sup>3</sup>                               | \$40                                        | \$35                                            |
| <b>Preventive care</b>                                | \$0                                         | \$0                                             |
| <b>Emergency care</b>                                 | \$90                                        | \$90                                            |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum. **3-** Services may require a physician referral.



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

| Regence<br>Valiance (HMO) (no Rx)           | What you should know                                                                                                                      |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| H6237-006                                   |                                                                                                                                           |
| \$0                                         | You must continue to pay your Medicare Part B premium.                                                                                    |
| \$0                                         | Amount you pay for health care services before your health plan begins to pay. Deductible amounts reset every calendar year on January 1. |
| Not covered                                 |                                                                                                                                           |
| \$4,900                                     | Annual limit on your out-of-pocket costs for Part A (hospital) and Part B (medical) services. Does not include prescription drugs.        |
| <b>In-network</b>                           |                                                                                                                                           |
| Days 1-4: \$375 / day<br>Days 5+: \$0 / day | There is no limit/maximum to number of days.                                                                                              |
| \$35                                        |                                                                                                                                           |
| \$275                                       |                                                                                                                                           |
| \$35                                        |                                                                                                                                           |
| \$90                                        |                                                                                                                                           |
| \$300                                       |                                                                                                                                           |
| \$0                                         |                                                                                                                                           |
| \$35                                        |                                                                                                                                           |
| \$0                                         | Cost-sharing may apply if you receive other services during your preventive care visit.                                                   |
| \$90                                        | Copay waived if admitted to the hospital within 48 hours.                                                                                 |

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|                                                          | Regence <b>BlueAdvantage HMO</b>                                  | Regence <b>BlueAdvantage HMO Plus</b>                             |
|----------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|
|                                                          | <b>In-network</b>                                                 | <b>In-network</b>                                                 |
| <b>Urgently needed services</b>                          | \$40                                                              | \$35                                                              |
| <b>Diagnostic services/labs/imaging</b>                  |                                                                   |                                                                   |
| Lab services <sup>1</sup>                                | \$0 - \$5                                                         | \$0 - \$5                                                         |
| Outpatient X-rays                                        | \$5                                                               | \$5                                                               |
| Diagnostic tests and procedures <sup>1</sup>             | \$5                                                               | \$5                                                               |
| Diagnostic radiology (MRI, CT, etc.) <sup>1</sup>        | 20%                                                               | 20%                                                               |
| <b>Hearing services</b>                                  |                                                                   |                                                                   |
| Medical hearing exam                                     | \$40                                                              | \$35                                                              |
| Routine hearing exam <sup>2</sup>                        | \$0                                                               | \$0                                                               |
| Hearing aids (1 per ear, per year) <sup>2</sup>          | \$699 or \$999 per aid                                            | \$699 or \$999 per aid                                            |
| <b>Dental services</b>                                   |                                                                   |                                                                   |
| Medical dental services                                  | \$40                                                              | \$35                                                              |
| Preventive dental services <sup>2</sup>                  | \$0                                                               | \$0                                                               |
| Comprehensive dental services - diagnostic <sup>2</sup>  | Not covered; available as an optional supplemental benefit        | \$0                                                               |
| Comprehensive dental services - restorative <sup>2</sup> | Not covered; available as an optional supplemental benefit        | Not covered; available as an optional supplemental benefit        |
| <b>Vision services</b>                                   |                                                                   |                                                                   |
| Medical vision services                                  | \$0                                                               | \$0                                                               |
| Routine vision exam <sup>2</sup>                         | \$0                                                               | \$0                                                               |
| Routine vision hardware <sup>2</sup>                     | Lenses: \$0<br>Frames or contact lenses: \$100 allowance per year | Lenses: \$0<br>Frames or contact lenses: \$100 allowance per year |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum. **3-** Services may require a physician referral.

| Regence<br>Valiance (HMO) (no Rx)                                 | What you should know                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>In-network</b>                                                 |                                                                                                                                                                                                                                                        |
| \$35                                                              |                                                                                                                                                                                                                                                        |
| \$0 - \$5                                                         | Lower copay amount applies to HbA1C testing; higher copay applies to all other lab services.                                                                                                                                                           |
| \$5                                                               |                                                                                                                                                                                                                                                        |
| \$5                                                               |                                                                                                                                                                                                                                                        |
| 20%                                                               |                                                                                                                                                                                                                                                        |
| \$35                                                              |                                                                                                                                                                                                                                                        |
| \$0                                                               | Routine hearing services provided by TruHearing® for in-network coverage. Hearing aids covered only if obtained from TruHearing.                                                                                                                       |
| \$699 or \$999 per aid                                            |                                                                                                                                                                                                                                                        |
| \$35                                                              |                                                                                                                                                                                                                                                        |
| \$0                                                               | Covers preventive exams, bitewing X-rays, cleanings and topical fluoride two times per calendar year. Full-mouth X-rays covered once every three years.                                                                                                |
| \$0                                                               | Covers diagnostic exams and intraoral-periapical X-rays two times per calendar year.                                                                                                                                                                   |
| Not covered; available as an optional supplemental benefit        | Covers crowns, dentures, partials, bridges, implants, restorations, endodontics, periodontics and oral surgery.                                                                                                                                        |
| \$0                                                               |                                                                                                                                                                                                                                                        |
| \$0                                                               | Routine vision services provided by VSP® Vision Care for in-network coverage. Covered lenses include basic single-vision, lined bifocal, lined trifocal or lenticular lenses. One pair of lenses/frames or single purchase of contact lenses per year. |
| Lenses: \$0<br>Frames or contact lenses: \$100 allowance per year |                                                                                                                                                                                                                                                        |

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**3-** Services may require a physician referral.



|                                                      | Regence <b>BlueAdvantage HMO</b>                 | Regence <b>BlueAdvantage HMO Plus</b>            |
|------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
|                                                      | <b>In-network</b>                                | <b>In-network</b>                                |
| <b>Mental health services<sup>1</sup></b>            |                                                  |                                                  |
| Inpatient                                            | Days 1-4: \$375 / day<br>Days 5-190: \$0 / day   | Days 1-4: \$375 / day<br>Days 5-190: \$0 / day   |
| Outpatient therapy (individual and group)            | \$40                                             | \$35                                             |
| <b>Skilled nursing facility<sup>1</sup></b>          | Days 1-20: \$0 / day<br>Days 21-100: \$167 / day | Days 1-20: \$0 / day<br>Days 21-100: \$167 / day |
| <b>Physical therapy<sup>1</sup></b>                  | \$40                                             | \$35                                             |
| <b>Ambulance (air/ground)<sup>1</sup></b>            | \$225                                            | \$275                                            |
| <b>Transportation</b>                                | Not covered                                      | Not covered                                      |
| <b>Medicare Part B drugs<sup>1</sup></b>             | 20%                                              | 20%                                              |
| <b>Alternative care</b>                              |                                                  |                                                  |
| Acupuncture (Medicare-covered)                       | \$20                                             | \$20                                             |
| Acupuncture (additional) <sup>2</sup>                | \$20                                             | \$20                                             |
| Chiropractic (Medicare-covered)                      | \$20                                             | \$20                                             |
| Chiropractic (additional) <sup>2</sup>               | \$20                                             | \$20                                             |
| Massage therapy <sup>2</sup>                         | \$20                                             | \$20                                             |
| Naturopathy <sup>2</sup>                             | \$20                                             | \$20                                             |
| <b>Annual physical exam</b>                          | \$0                                              | \$0                                              |
| <b>Fitness program (Silver&amp;Fit®)<sup>2</sup></b> | \$0                                              | \$0                                              |
| <b>Meal delivery service<sup>2</sup></b>             |                                                  |                                                  |
| Chronic health status                                | \$0                                              | \$0                                              |
| Post-discharge                                       | \$0                                              | \$0                                              |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum. **3-** Services may require a physician referral.

Regence  
**Valiance (HMO) (no Rx)**

**What you should know**

| <b>In-network</b>                                |                                                                                                                    |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Days 1-4: \$375 / day<br>Days 5-190: \$0 / day   | There is a 190-day lifetime maximum.                                                                               |
| \$35                                             |                                                                                                                    |
| Days 1-20: \$0 / day<br>Days 21-100: \$167 / day | Up to 100 days covered per benefit period.                                                                         |
| \$35                                             | Includes occupational therapy and speech language therapy.                                                         |
| \$250                                            | Copay applies for each one-way transport.                                                                          |
| Not covered                                      |                                                                                                                    |
| 20%                                              | Usually administered in a hospital setting, like chemotherapy drugs.                                               |
| \$20                                             | Limited to treatment of chronic low back pain.                                                                     |
| \$20                                             | Up to 18 visits per year combined with additional chiropractic visits.                                             |
| \$20                                             | Limited to manipulation of the spine to correct a subluxation.                                                     |
| \$20                                             | Up to 18 visits per year combined with additional acupuncture visits.                                              |
| \$20                                             | Limit of 6 visits per year; up to 60 minutes per visit.                                                            |
| \$20                                             | Limit of 6 visits per year.                                                                                        |
| \$0                                              | In addition to the Medicare Annual Wellness Visit.                                                                 |
| \$0                                              | Fitness center membership, home fitness options including a complimentary Fitbit, weekly health coaching and more. |
| \$0                                              | Requires enrollment in care management program.<br>Chronic health: 2 meals/day for 56 days, 112-meal limit.        |
| \$0                                              | Post-discharge: 2 meals per day, 28 days, 56-meal limit.                                                           |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum.  
**3-** Services may require a physician referral.

|                                                              | Regence <b>BlueAdvantage HMO</b> | Regence <b>BlueAdvantage HMO Plus</b> |
|--------------------------------------------------------------|----------------------------------|---------------------------------------|
|                                                              | <b>In-network</b>                | <b>In-network</b>                     |
| <b>Over-the-counter items<sup>2</sup></b>                    | \$40 every 3 months              | Not covered                           |
| <b>Palliative care and support<sup>2</sup></b>               | \$0                              | \$0                                   |
| <b>Personal emergency response system (PERS)<sup>2</sup></b> | \$0                              | \$0                                   |
| <b>Podiatry services</b>                                     |                                  |                                       |
| Medicare-covered                                             | \$40                             | \$35                                  |
| Diabetic routine foot care <sup>2</sup>                      | \$0                              | \$0                                   |
| <b>Virtual companionship<sup>2</sup></b>                     | \$0                              | \$0                                   |
| <b>Virtual visits (telehealth)</b>                           | \$0                              | \$0                                   |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum. **3-** Services may require a physician referral.



Regence  
**Valiance (HMO) (no Rx)**

**What you should know**

| <b>In-network</b>   |                                                                                                                                           |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| \$40 every 3 months | Unused balance does not accumulate or carry over from quarter to quarter.                                                                 |
| \$0                 | Includes care planning, pain/symptom management and counseling services for patients, caregivers and families in case of serious illness. |
| \$0                 | Benefit includes device and monthly monitoring services.                                                                                  |
| \$35                |                                                                                                                                           |
| \$0                 | Limit of 6 visits per year.                                                                                                               |
| \$0                 | Virtual support services by phone. Limit of 4 visits per month; up to 60 minutes per visit.                                               |
| \$0                 | Medical and mental health services provided by MDLIVE® or other provider by phone or video.                                               |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum.  
**3-** Services may require a physician referral.

|                                | Regence <b>BlueAdvantage HMO</b>       | Regence <b>BlueAdvantage HMO Plus</b>  |
|--------------------------------|----------------------------------------|----------------------------------------|
| <b>Prescription deductible</b> | \$0 (Tiers 1,2)<br>\$200 (Tiers 3,4,5) | \$0 (Tiers 1,2)<br>\$100 (Tiers 3,4,5) |

**Initial coverage** (after deductible, what you pay until you and the plan pay \$4,130 for prescription drugs)

| <b>Tier 1: Preferred generic</b>  | <b>1-month</b> | <b>3-month</b> | <b>1-month</b> | <b>3-month</b> |
|-----------------------------------|----------------|----------------|----------------|----------------|
| Preferred retail                  | \$3            | \$0            | \$3            | \$0            |
| Mail order                        | \$0            | \$0            | \$0            | \$0            |
| Standard retail                   | \$10           | \$20           | \$10           | \$20           |
| <b>Tier 2: Generic</b>            |                |                |                |                |
| Preferred retail / mail order     | \$12           | \$24           | \$8            | \$16           |
| Standard retail                   | \$19           | \$38           | \$15           | \$30           |
| <b>Tier 3: Preferred brand</b>    |                |                |                |                |
| Preferred retail / mail order     | \$40           | \$100          | \$40           | \$100          |
| Standard retail                   | \$47           | \$117.50       | \$47           | \$117.50       |
| <b>Tier 4: Non-preferred drug</b> |                |                |                |                |
| Preferred retail / mail order     | 40%            | 40%            | 40%            | 40%            |
| Standard retail                   | 45%            | 45%            | 45%            | 45%            |
| <b>Tier 5: Specialty</b>          |                |                |                |                |
| Preferred retail / mail order     | 29%            | N/A            | 31%            | N/A            |
| Standard retail                   | 29%            | N/A            | 31%            | N/A            |

**Coverage gap** (what you pay after you and your plan pay \$4,130 for prescription drugs)

|                  |             |
|------------------|-------------|
| Generic drugs    | You pay 25% |
| Brand-name drugs | You pay 25% |

**Catastrophic coverage** (what you pay after your total out-of-pocket costs reach \$6,550)

|                  |                                     |
|------------------|-------------------------------------|
| Generic drugs    | You pay the greater of \$3.70 or 5% |
| Brand-name drugs | You pay the greater of \$9.20 or 5% |

You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy. Long-term care facility residents pay the same as at a standard retail pharmacy and are limited to a one-month supply (three-month supply is not available). Cost-sharing may change if you qualify for Extra Help. To find out if you qualify, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778) between 7 a.m. and 7 p.m., Monday through Friday.

## Optional supplemental dental benefits

|                                                                                       | Dental Option I<br>(for BlueAdvantage HMO plan)                                    | Dental Option II<br>(for BlueAdvantage HMO Plus<br>and Valiance plans) |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Monthly plan premium</b><br>(in addition to your monthly plan and Part B premiums) | \$24                                                                               | \$24                                                                   |
|                                                                                       | <b>In-network</b>                                                                  | <b>In-network</b>                                                      |
| <b>Comprehensive dental services<sup>2</sup></b>                                      | 50%; \$1,000 benefit limit per calendar year for all comprehensive dental services | Included in standard medical benefits                                  |
| Diagnostic                                                                            |                                                                                    |                                                                        |
| Restorative                                                                           | 50%; \$1,000 benefit limit per calendar year                                       |                                                                        |

**1-** Services may require prior authorization. **2-** Services do not apply to the out-of-pocket maximum.  
**3-** Services may require a physician referral.



## Pre-enrollment checklist

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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 **1-855-522-8896**.

### 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](https://www.regence.com/medicare) or call **1-855-522-8896** 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, 2022.
- 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).

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### Covered preventive care services

Our plans cover the following Medicare-covered preventive services, along with any additional preventive services that Medicare approves during the contract year.

|                                           |                                                                                                                                             |                                                          |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Abdominal aortic aneurysm screening       | Colorectal cancer screenings (multi-target stool DNA test, barium enemas, colonoscopy, fecal occult blood test or flexible sigmoidoscopies) | Tomography (LDCT)                                        |
| Alcohol misuse screenings and counseling  | Depression screening                                                                                                                        | Medicare Diabetes Prevention Program (MDPP)              |
| Annual Wellness Visit                     | Diabetes screening                                                                                                                          | Nutrition therapy services                               |
| Bone mass measurements (bone density)     | Diabetes self-management training                                                                                                           | Obesity screenings and counseling                        |
| Breast cancer screening (mammogram)       | Glaucoma tests                                                                                                                              | Prostate cancer screenings                               |
| Cardiovascular disease screenings         | Hepatitis B virus (HBV) infection screening                                                                                                 | Sexually transmitted infections screening and counseling |
| Cardiovascular disease behavioral therapy | Hepatitis C screening test                                                                                                                  | Immunizations for flu, hepatitis B and pneumococcus      |
| Cervical and vaginal cancer screening     | HIV screening                                                                                                                               | Tobacco use cessation counseling                         |
|                                           | Lung cancer screenings with Low Dose Computed                                                                                               | “Welcome to Medicare” preventive visit (one time)        |

## Important information about benefits

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### Routine hearing services

For more information about your routine hearing benefits or to find a hearing provider, call TruHearing at **1-855-542-1711** (TTY: 711), 8 a.m. to 8 p.m. Monday through Friday. Or visit [truhearing.com](https://truhearing.com).

### Routine vision services

For more information about your routine vision benefits or to find a vision provider, call VSP Vision Care at **1-844-299-3401** (TTY: 1-800-428-4833), 5 a.m. to 6 p.m. Pacific time, Monday through Friday, or 7 a.m. to 5 p.m. Pacific time, Saturday and Sunday. Or visit [vsp.com](https://vsp.com).

### Virtual companionship

Eligible members are able to receive support services, such as grocery and pharmacy pick-up/delivery, technology assistance, phone visits and more. For more information or to see if you qualify, call Papa Pals at **1-877-310-0303** (TTY: 711) 5 a.m. to 8 p.m. Pacific time, Monday through Friday, or 5 a.m. to 5 p.m. Pacific time, Saturday and Sunday. Or visit [Joinpapa.com/Regence](https://Joinpapa.com/Regence).

### The Silver&Fit program

Includes a basic membership at one or more participating fitness centers, plus an expanded home fitness program with two home fitness kits, one Stay Fit kit (Fitbit, Garmin, yoga or strength training), weekly 1-to-1 health coaching, and more. For more information or to sign up, call Silver&Fit at **1-888-797-8086** (TTY: 711), 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Or visit [SilverandFit.com](https://SilverandFit.com).

### Over-the-counter items

Members of select plans receive a prepaid discount card and a list of product categories that are eligible for the OTC program. Allowance renews each quarter; unused credit does not accumulate or carry over to the next quarter. The card can be used at participating retail locations or online at [NationsOTC.com](https://NationsOTC.com). For more information, call Regence Customer Service at **1-855-522-8896** (TTY: 711).

### Meal delivery service

No-cost meals for chronic condition or post-hospital stay nutritional support for those who qualify and participate in the plan's care/case management program. Mom's Meals delivers meals to all 50 states plus U.S. territories. For more information or to see if you qualify, call Regence Customer Service at **1-855-522-8896** (TTY: 711).

### Personal emergency response system (PERS)

Receive a Lively™ Mobile Plus medical alert device and monthly monitoring per calendar year when arranged by the plan. For more information, call GreatCall at **1-800-358-9066** (TTY: 711). Or visit [greatcall.com/RegenceOR](https://greatcall.com/RegenceOR).

### Virtual visits (telehealth)

Primary care and mental health visits are available by mobile app, video or phone. For more information or to schedule an appointment, call MDLIVE at **1-800-400-6354** (TTY: 711), 24 hours a day, 7 days a week. Or visit [mdlive.com](https://mdlive.com).

### 24-hour nurse line

Regence Advice24 gives you 24/7 access to a medical professional for self-care suggestions for minor injuries and illnesses or help determining if an urgent care facility or emergency room is needed for more immediate care. Call **1-800-267-6729** (TTY: 711).

### Urgent and emergency care when you travel

If you travel outside the United States, the plan covers urgent care and medical emergencies in more than 190 countries around the world. Part D prescription drug coverage is not available outside the United States and its territories.

**Regence Medicare Advantage Plans  
Monthly Plan Premium for People who get Extra Help from Medicare  
to Help Pay for their Prescription Drug Costs**

If you get extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get extra help from Medicare. The amount of extra help you get will determine your total monthly plan premium as a member of our Plan.

This table shows you what your monthly plan premium will be if you get extra help.

**HMO plans available in Deschutes County in Oregon**

| Your level of extra help | Monthly Premium for Regence BlueAdvantage HMO* | Monthly Premium for Regence BlueAdvantage HMO PLUS* |
|--------------------------|------------------------------------------------|-----------------------------------------------------|
| 100%                     | \$27.30                                        | \$71.10                                             |
| 75%                      | \$32.70                                        | \$75.30                                             |
| 50%                      | \$38.10                                        | \$79.50                                             |
| 25%                      | \$43.60                                        | \$83.80                                             |

\*This does not include any Medicare Part B premium you may have to pay.

Regence BlueAdvantage HMO and Regence BlueAdvantage HMO Plus premiums include coverage for both medical services and prescription drug coverage.

If you aren't getting extra help, you can see if you qualify by calling:

- 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778 between 7 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please call Customer Service at **1-855-522-8896** (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday (from October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week).

You must continue to pay your Medicare Part B premium. Regence optional supplemental benefit plan members must continue to pay their optional supplemental benefit plan premium.

# Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face or telephonic appointment sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

**Please initial below beside the type of product(s) you want the agent to discuss.**

(Refer to page 2 for product type descriptions)

**Stand-alone Medicare Prescription Drug Plans (Part D)**

**Hospital Indemnity Products**

**Medicare Advantage Plans (Part C) and Cost Plans**

**Medicare Supplement (Medigap) Products**

**Dental/Vision/Hearing Products**

**By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.** Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

|                                                                                                                                                 |                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| Beneficiary or Authorized Representative Signature and Signature Date:                                                                          |                                       |
| Signature:                                                                                                                                      | Signature Date:                       |
| If you are the authorized representative, please sign above and print below:                                                                    |                                       |
| Representative's Name:                                                                                                                          | Your Relationship to the Beneficiary: |
| To be completed by Agent:                                                                                                                       |                                       |
| Agent Name:                                                                                                                                     | Agent Phone:                          |
| Beneficiary Name:                                                                                                                               | Beneficiary Phone (Optional):         |
| Beneficiary Address (Optional):                                                                                                                 |                                       |
| Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)                                                                        |                                       |
| Agent's Signature:                                                                                                                              |                                       |
| Plan(s) the agent represented during this meeting:                                                                                              | Date Appointment Completed:           |
| [Plan Use Only:]                                                                                                                                |                                       |
| Agent, if the form was not signed by the beneficiary prior to the appointment, provide explanation why SOA was not documented prior to meeting: |                                       |

\*Scope of Appointment documentation is subject to CMS record retention requirements \*



## Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

## Medicare Advantage Plans (Part C) and Cost Plans

**Medicare Health Maintenance Organization (HMO)** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

**Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare Private Fee-For-Service (PFFS) Plan** — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Point of Service (POS) Plan** — A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

**Medicare Special Needs Plan (SNP)** — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

**Medicare Medical Savings Account (MSA) Plan** — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare Cost Plan** — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

## Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

## Hospital Indemnity Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

## Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

PO Box 1827  
Medford, OR 97501  
1 (844) REGENCE  
(1 (844) 734-3623)  
Fax number 1 (888) 335-2988  
TTY 711

## Regence Medicare Advantage Plans (HMO) Enrollment Request Form

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### ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

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#### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

#### To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

#### When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

#### What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Member Requested Effective Date: \_\_\_\_\_  
(Must have a valid enrollment election for the effective date requested.)

**Note:** You must complete all items in Section 1. **Once you're finished, don't forget to sign and date the form.** The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

#### Reminders:

- If you want to join a plan during fall annual open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

#### What happens next?

Send your completed and signed form to:  
Regence Medicare Advantage Plan  
PO Box 1827  
Medford, OR 97501

Once they process your request to join, they'll contact you.

#### How do I get help with this form?

Call Regence Medicare Advantage Plans at 1 (855) 522-8896. TTY users can call 711. Our telephone hours are 8 a.m. to 8 p.m. Monday through Friday. From October 1 through March 31, Customer Service is available from 8 a.m. to 8 p.m., seven days a week.

Or, call Medicare at 1 (800) MEDICARE (1 (800) 633-4227). TTY users can call 1 (877) 486-2048.

**En español:** Llame a Regence al 1 (855) 522-8896, TTY 711 o a Medicare gratis al 1 (800) 633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

## Individual Enrollment Request Form

**Section 1 – To Enroll in Regence Medicare Advantage Plans, Please Provide the Following Information:**

**Please check which plan you want to enroll in:  
Regence BlueAdvantage HMO County = Deschutes**

- Regence BlueAdvantage HMO \$49.00 (H6237-007-003)
- Dental Option I (only for Regence BlueAdvantage HMO) \$24.00
- Regence Valiance (HMO) (No Rx) \$0.00 (H6237-006)
- Regence BlueAdvantage HMO Plus \$88.00 (H6237-008-003)
- Dental Option II (only for Regence Valiance (HMO) or Regence BlueAdvantage HMO Plus) \$24.00

Please print clearly

|             |            |                 |
|-------------|------------|-----------------|
| FIRST name: | LAST Name: | Middle Initial: |
|-------------|------------|-----------------|

|                          |                                                                       |                    |                                         |
|--------------------------|-----------------------------------------------------------------------|--------------------|-----------------------------------------|
| Birth Date: (MM/DD/YYYY) | Sex:<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Home Phone Number: | Alternate Phone Number<br>(Cell Phone): |
|--------------------------|-----------------------------------------------------------------------|--------------------|-----------------------------------------|

*I consent to be contacted at the telephone number I have provided above from or on behalf of Regence, healthcare providers, or their respective agents. These calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment or billing.*

Permanent Residence Street Address (Don't enter a PO Box):

|       |        |           |        |
|-------|--------|-----------|--------|
| City: | State: | ZIP Code: | County |
|-------|--------|-----------|--------|

Mailing address, if different from your permanent address (PO Box allowed):

|       |        |           |
|-------|--------|-----------|
| City: | State: | ZIP Code: |
|-------|--------|-----------|

E-mail address:

*By providing your email, you give permission to be contacted about future Medicare news and plan information via email. You may opt out of email communication at any time.*

**Your Medicare information:**

**Medicare Number:**

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Regence Medicare Advantage Plan?  Yes  No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: \_\_\_\_\_

ID Number for this coverage: \_\_\_\_\_

Group Number for this coverage: \_\_\_\_\_

Effective Date \_\_\_\_\_ RX Bin # \_\_\_\_\_ PCN # \_\_\_\_\_

Are you a resident in a long-term care facility, such as a nursing home?  Yes  No

If "yes," please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

**Typically, you may enroll in a Medicare Advantage Plan only during the annual enrollment period from October 15 through December 7 of each year.** Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage Plan outside of the annual enrollment period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- Annual Enrollment Period
- I am new to Medicare. (Enrollment election period is up to 3 months prior to Medicare A & B entitlement dates).
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) between January 1st and March 31st.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_
- I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_
- I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) \_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help, or lost Extra Help) on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_
- I recently left a PACE program on (insert date) \_\_\_\_\_
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) \_\_\_\_\_.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) \_\_\_\_\_



I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Regence Medicare Advantage Plans at 1 (855) 522-8896 (TTY users should call 711) to see if you are eligible to enroll. We are open from 8 a.m. to 8 p.m., Monday through Friday. From October 1 through March 31, our telephone hours are 8 a.m. to 8 p.m., seven days a week.

**Section 2 – Answering these following 4 questions is your choice.  
You can't be denied coverage because you don't fill them out.**

1. If you have a Medigap policy and join a **Medicare Advantage Plan (Part C)**, you may want to drop your Medigap policy. Your Medigap policy can't be used to pay your Medicare Advantage Plan copayments, deductibles and premiums. If you have Medigap coverage with another carrier, please contact them for disenrollment.

Are you currently enrolled in a Regence individual medical plan or Medicare supplement plan?

Yes  No

If yes, do you wish to terminate that coverage?  Yes  No

**If you answered "yes" to both questions above, please sign the statement below:**

I, \_\_\_\_\_, wish to terminate my Regence individual medical plan or Medicare supplement plan effective on the date of this Regence Medicare Advantage policy. If you have dependents covered under your existing plan, please contact that plan to discuss their enrollment.

**Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

2. Do you work?  Yes  No Does your spouse work?  Yes  No

**3. Please choose the name of a Primary Care Physician (PCP), clinic, or health center:**

**First and Last Name of PCP:** \_\_\_\_\_

PCP Address: \_\_\_\_\_

PCP Phone Number: \_\_\_\_\_

4. Select one if you want us to send you information in a language other than English or in an accessible format.

Please check this box if you'd like to be contacted concerning any other available languages

Please check this box if you'd like to be contacted concerning any other available formats

Please contact Regence Medicare Advantage Plans at 1 (855) 522-8896 if you need information in an accessible format or language other than what's listed above. Our office hours are 8 a.m. to 8 p.m. Monday through Friday. From October 1 through March 31, Customer Service is available from 8 a.m. to 8 p.m., seven days a week. TTY users should call 711.

Evidence of Coverage, Drug List (formulary), and Provider Directories are provided in electronic versions available online at regence.com. To request print versions, contact Customer Service.

**You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, online, by phone or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778. You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

**Please select one of the three premium payment options below:**

- Get a bill (A billing statement will be sent in the mail)
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a preprinted VOIDED check or provide the following:

Account Holder Name: \_\_\_\_\_

If Account Holder name is NOT the name of the applicant on this application, please sign below to authorize deductions: \_\_\_\_\_

(Signature of Account Holder)

Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_

Account type:  Checking  Savings

- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from:  Social Security  RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premium due from your enrollment effective date up to the point withholding begins. If the first deduction does not include all premiums, you will be responsible for paying your premiums directly to the plan until Social Security or RRB deductions start. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Additional Payment options available:**

- Pay online - This is the fastest and easiest way to pay. Plus, it's safe and convenient. Just go to [Regence.com/paying-premiums](http://Regence.com/paying-premiums).
- Pay by phone - Call our automated payment system at 1 (888) 431-2063. Have your banking information and member ID number ready.

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Regence Medicare Advantage the Part D-IRMAA.

**IMPORTANT: Read and Sign Below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Regence Medicare Advantage Plans.
- By joining this Medicare Advantage Plan, I acknowledge that Regence Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Regence Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Regence Medicare Advantage. Benefits and services provided by Regence Medicare Advantage and contained in my Regence Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Regence Medicare Advantage will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

**Signature:**

**Today's Date:**

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone Number:

Relationship to enrollee:

Agent Name Tiffany Jackson Agent Number 0102279-0009  
 Agent Phone Number (including area code) 800.884.2343  
 Agent Signature \_\_\_\_\_  
 Agent Application Received Date \_\_\_\_\_

**Regence Office Use Only**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_  
 Plan ID#: \_\_\_\_\_  
 Effective Date of Coverage: \_\_\_\_\_  
 ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

## 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'déé', t'áá jiik'eh, éí ná hóló, koji' 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៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល្អ គឺអាចមានសរាប់បំរើអ្នក។ 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)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ- 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिपिवाइ: 711)

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

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذا ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)



This document is available electronically and may be available in other formats. A complete list of covered services can be found in our Evidence of Coverage (EOC) on our website at [regence.com/medicare](https://www.regence.com/medicare) or by calling **1-855-522-8896** (TTY: 711). Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Some services require prior authorization from us before you receive treatment. This process helps you understand your treatment options and risks, ensure treatment is supported by available medical evidence and avoid inappropriate or unnecessary treatment and costs. Some covered drugs may have additional requirements or limits on coverage, such as prior authorization, step therapy or quantity limits. Contact Customer Service if you have questions about coverage requirements or prior authorizations. You can view the annual notice of member rights regarding privacy practices and how we protect your information at [regence.com/medicare](https://www.regence.com/medicare).

Out-of-network/non-contracted providers are under no obligation to treat Regence members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For accommodations of persons with special needs at meetings call **1-800-557-0555** (TTY: 711).

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 [medicare.gov](https://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.

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American Specialty Health Incorporated, GreatCall, MDLIVE, Mom's Meals, NationsOTC, Papa Pals, TruHearing and VSP are separate and independent companies that provide services to Regence members.

## For more information

Call our Regence Medicare plan advisors at  
**1-844-REGENCE** (1-844-734-3623) (TTY: 711),  
8 a.m. to 5 p.m., Monday through Friday.



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