Regence

2020 HMO Summary of Benefits

for Whatcom County

H1997_WAWCHMO20SB_M

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. Services from out-of-network providers are not covered, except in urgent/emergent situations or if there are no in-network providers for the service needed.

	Regence **BlueAdvantage HMO No Rx**	Regence **Align HMO**	Regence **Align HMO Plus**
Monthly plan premium	You must continue to pay your Medicare Part B premium.		
	$0	$0	$34
Deductible			
Medical	$0	$0	$0
Prescription	Not covered	$0 (Tiers 1,2) $250 (Tiers 3,4,5)	$0 (Tiers 1,2) $100 (Tiers 3,4,5)
Maximum out-of-pocket responsibility is the yearly limit on your out-of-pocket costs for hospital or medical services. Some services and prescription drugs do not apply to the maximum out-of-pocket.			
	$5,900	$6,200	$5,900
Inpatient hospital coverage[1]			
	Days 1-4: $430 / day Days 5+: $0 / day	Days 1-4: $430 / day Days 5+: $0 / day	Days 1-4: $390 / day Days 5+: $0 / day
Ambulatory surgery center[1]			
For wound care	$45	$45	$45
For all other services	$225	$300	$225
Outpatient hospital coverage[1]			
For wound care	$45	$45	$45
For observation	$90	$90	$90
For all other services	$275	$350	$275

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 HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area of **Whatcom County** in Washington.

	Regence **BlueAdvantage HMO No Rx**	Regence **Align HMO**	Regence **Align HMO Plus**
Doctor visits			
Primary care visit	$10	$10	$5
Specialist visit[3]	$45	$45	$45
Preventive care			
	$0	$0	$0
Emergency care	Waived if admitted to hospital within 48 hours.		
	$90	$90	$90
Urgently needed services			
	$45	$45	$45
Diagnostic services/labs/imaging			
Lab services[1]	$25	$20	$20
Outpatient X-rays	$20	$20	$20
Diagnostic tests and procedures[1]	$25	$20	$20
Diagnostic radiology (MRI, CAT, etc.)[1]	20%	20%	20%
Hearing services	Routine hearing exam and hearing aids provided by TruHearing® only.		
Medical hearing exam[3]	$45	$45	$45
Routine hearing exam[2]	$45	$45	$45
Hearing aids (1 per ear, per year)[2]	$699 or $999 per aid	$699 or $999 per aid	$699 or $999 per aid

1- *Services may require prior authorization.* ***2-*** *Services do not apply to the out-of-pocket maximum.*
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	Regence **BlueAdvantage HMO No Rx**	Regence **Align HMO**	Regence **Align HMO Plus**
Dental services			
Medical dental exam[3]	$45	$45	$45
Preventive dental services (exam, X-rays, cleaning, flouride)[2]	$0	Not covered; available as an optional supplemental benefit	$0
Comprehensive dental services [2]	Not covered; available as an optional supplemental benefit	Not covered	Not covered; available as an optional supplemental benefit
Vision services	Routine vision exam and hardware provided by VSP® Vision Care only.		
Medical vision services[3]	$0	$0	$0
Routine vision exam[2]	$0	Not covered; available as an optional supplemental benefit	$0
Routine vision hardware (one pair of lenses/frames or single purchase of contact lenses per year)[2]	Lenses: $0 (basic single vision, lined bifocal, lined trifocal or lenticular lenses) Frames or contact lenses: Up to $100 allowance	Not covered; available as an optional supplemental benefit	Lenses: $0 (basic single vision, lined bifocal, lined trifocal or lenticular lenses) Frames or contact lenses: Up to $100 allowance
Mental health services[1]			
Inpatient	Days 1-4: $390 / day Days 5-190: $0 / day	Days 1-4: $390 / day Days 5-190: $0 / day	Days 1-4: $390 / day Days 5-190: $0 / day
Outpatient therapy (individual and group)	$40	$40	$40
Skilled nursing facility[1]	Up to 100 days covered per benefit period.		
	Days 1-20: $0 / day Days 21-100: $167 / day	Days 1-20: $0 / day Days 21-100: $167 / day	Days 1-20: $0 / day Days 21-100: $167 / day
Physical therapy[1]	Includes occupational therapy and speech language therapy.		
	$40	$40	$40

***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 **BlueAdvantage HMO No Rx**	Regence **Align HMO**	Regence **Align HMO Plus**
Ambulance[1]	Copay applies for each one-way transport.		
	$275	$275	$275
Transportation			
	Not covered	Not covered	Not covered
Medicare Part B drugs[1]	Usually administered in a hospital setting, like chemotherapy drugs.		
	20%	20%	20%
Alternative care[2]	Acupuncture, naturopathy and routine chiropractic have a combined total limit of 18 visits every year. Massage therapy is limited to 6 visits per year.		
Acupuncture	$20	Not covered	Not covered
Chiropractic (routine)	$20	Not covered	Not covered
Massage therapy	$20	Not covered	Not covered
Naturopathy	$20	Not covered	Not covered
Annual physical exam	In addition to the Medicare Annual Wellness Visit.		
	$0	$0	$0
Chiropractic care (Medicare-covered)	Limited to manipulation of the spine to correct a subluxation.		
	$20	$20	$20
Fitness membership	Provided by the Silver&Fit® program.		
	$0	$0	$0
Meal delivery service[1,2]	Requires inpatient stay up to 30 days prior; 2 meals per day, 56-meal limit.		
	$0	$0	$0
Telehealth visits	Services provided by MDLIVE® or other provider by phone or video chat.		
	$10	$10	$10

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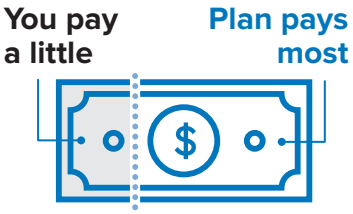
	Regence **Align HMO**	Regence **Align HMO Plus**
Prescription deductible	$0 (Tiers 1,2) $250 (Tiers 3,4,5)	$0 (Tiers 1,2) $100 (Tiers 3,4,5)
Stage 1: Initial coverage stage (until prescription costs reach $4,020)		
1-month supply	Preferred retail and mail-order / standard retail, out-of-network[1] and LTC facility[2]	
Tier 1: Preferred generic	$3 / $10	$3 / $10
Tier 2: Generic	$12 / $19	$12 / $19
Tier 3: Preferred brand	$40 / $47	$40 / $47
Tier 4: Non-preferred drug	40% / 45%	40% / 45%
Tier 5: Specialty	28%	31%
3-month supply	Preferred retail and mail-order / standard retail	
Tier 1: Preferred generic	$6 / $20	$6 / $20
Tier 2: Generic	$24 / $38	$24 / $38
Tier 3: Preferred brand	$100 / $117.50	$100 / $117.50
Tier 4: Non-preferred drug	40% / 45%	40% / 45%
Tier 5: Specialty	Not available, limited to a 30-day supply (31-day for LTC facility)	
Stage 2: Coverage gap stage (after prescription costs reach $4,020)		
Generic drugs	You pay 25%	
Brand-name drugs	You pay 25%	
Stage 3: Catastrophic coverage stage (after you have paid $6,350 out of pocket)		
Generic drugs	You pay the greater of $3.60 or 5%	
Brand-name drugs	You pay the greater of $8.95 or 5%	

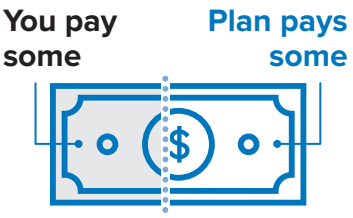
1- *You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy.* ***2-*** *Long-term care facility (31-day supply).*

Additional prescription information for HMO plans



Stage 1: Initial coverage phase

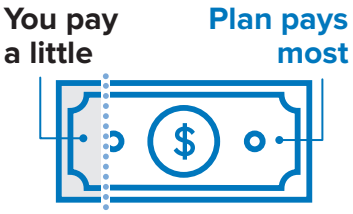
After you pay your annual deductible (if your plan has one), you pay a copay or coinsurance for each prescription you fill. Your plan pays the rest. You enter the coverage gap when the total amount you and your plan pay for covered drugs reaches **$4,020.**



Stage 2: Coverage gap phase

After you and your plan spend **$4,020,** you pay 25% of the plan's price for generic and brand-name prescription drugs.

You enter catastrophic coverage when your total out-of-pocket cost reaches **$6,350.** Only the amount you've paid in Stages 1 and 2 and the brand-name drug discount paid by the drug company count toward the total out-of-pocket.



Stage 3: Catastrophic coverage phase

After your total out-of-pocket reaches **$6,350,** you pay the greater of 5% coinsurance or **$3.60** copay for generic drugs, and the greater of 5% coinsurance or **$8.95** copay for brand-name drugs.

Your plan pays the rest of the cost of your prescription drugs for the rest of the calendar year (until Dec. 31).

How we cover prescription medications

We organize them into five tiers and assign a copay or coinsurance to each tier. What you pay depends on which tier your medication falls into. Check to see if the medication has limitations or restrictions, or requires prior authorization.

The formulary

Our list of covered prescription medications is selected and regularly reviewed by a committee of doctors and pharmacists for effectiveness, value and safety—not just price.

Save money on prescriptions

Use a preferred or mail-order pharmacy. You'll pay the lowest copay or coinsurance by using a preferred network or mail-order pharmacy.

Use generics. Ask your doctor about generics. They typically cost less than brand-names and work just as well.

Order a three-month supply. You'll save by ordering three months of your preferred generic, generic or preferred brand drugs.

	Regence **BlueAdvantage HMO No Rx**	Regence **Align HMO**	Regence **Align HMO Plus**
Optional supplemental benefits—dental and vision			
Monthly plan premium	In addition to your monthly HMO plan and Part B premiums.		
	$25	$20	$25
Dental services[2]			
Preventive dental services (exam, X-rays, cleaning, flouride)	Included in standard medical benefits	$0	Included in standard medical benefits
Comprehensive dental services	50%; $1,000 benefit limit per calendar year	Not covered	50%; $1,000 benefit limit per calendar year
Vision services[2]	Routine vision exam and hardware provided by VSP® Vision Care only.		
Routine vision exam	Included in standard medical benefits	$0	Included in standard medical benefits
Routine vision hardware	Included in standard medical benefits	Lenses: $0 (basic single vision, lined bifocal, lined trifocal or lenticular lenses) Frames or contact lenses: Up to $100 allowance	Included in standard medical benefits

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

Important information to know before you enroll

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-855-522-8896.**

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** 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, 2021.
- ☐ 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).

Covered preventive care

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

Alcohol misuse screenings and counseling

Annual Wellness Visit

Bone mass measurements (bone density)

Breast cancer screening (mammogram)

Cardiovascular disease screenings

Cardiovascular disease (behavioral therapy)

Cervical and vaginal cancer screening

Colorectal cancer screenings (multi-target stool DNA test, barium enemas, colonoscopy, fecal occult blood test or flexible sigmoidoscopies)

Depression screening

Diabetes screening

Diabetes self-management training

Glaucoma tests

Hepatitis B virus (HBV) infection screening

Hepatitis C screening test

HIV screening

Lung cancer screenings with Low Dose Computed Tomography (LDCT)

Medicare Diabetes Prevention Program (MDPP)

Nutrition therapy services

Obesity screenings and counseling

Prostate cancer screenings

Sexually transmitted infections screening and counseling

Immunizations for flu, hepatitis B and pneumococcus

Tobacco use cessation counseling

“Welcome to Medicare” preventive visit (one time)

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.

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Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ 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 (टिटिवाइ: 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, ໂດຍບໍ່ສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

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This document is available electronically and may be available in other formats. Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

A complete list of covered services can be found in our Evidence of Coverage (EOC) on our website at **regence.com/medicare** or by calling **1-855-522-8896** (TTY: 711). Out-of-network/noncontracted 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.

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

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein.

American Specialty Health Incorporated, MDLIVE, TruHearing and VSP are separate and independent companies that provide services to Regence members.

For more information

Prospective members call
1-844-734-3623 (TTY: 711)

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

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

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

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

REG-341328-19/08-WAWC