Regence

# 2020 PPO Summary of Benefits

for King, Kitsap, Pierce and Snohomish counties

H5009_WAPPO20SB_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.

| | Regence **MedAdvantage Basic (PPO) (no Rx)** | | Regence **MedAdvantage + Rx Primary (PPO)** | |
|---|---|---|---|---|
| **Monthly plan premium** | $0 | | $38 | |
| **Deductible** | | | | |
| Medical | $0 | | $0 | |
| Prescription | Not covered | | $0 (Tiers 1,2)<br>$340 (Tiers 3,4,5) | |
| **Maximum out-of-pocket responsibility** (does not include prescription drugs) | $6,200 (in-network)<br>$10,000 (combined in- and out-of-network) | | $6,700 (in-network)<br>$10,000 (combined in- and out-of-network) | |
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Inpatient hospital coverage**[1] | Days 1-4:<br>$390 / day<br>Days 5+:<br>$0 / day | Days 1+: 50% | Days 1-4:<br>$450 / day<br>Days 5+:<br>$0 / day | Days 1+: 50% |
| **Ambulatory surgery center services**[1] | | | | |
| For wound care | $40 | 50% | $50 | 50% |
| For all other services | $300 | 50% | $375 | 50% |
| **Outpatient hospital services**[1] | | | | |
| For wound care | $40 | 50% | $50 | 50% |
| For observation | $90 | 50% | $90 | 50% |
| For all other services | $350 | 50% | $450 | 50% |
| **Doctor visits** | | | | |
| Primary care provider | $20 | 50% | $25 | 50% |
| Specialist | $40 | 50% | $50 | 50% |

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

To join a Regence Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Washington: **King, Kitsap, Pierce** and **Snohomish.**

| Regence **MedAdvantage + Rx Classic (PPO)** | | Regence **MedAdvantage + Rx Enhanced (PPO)** | | **What you should know** |
|---|---|---|---|---|
| $78 | | $157 | | You must continue to pay your Medicare Part B premium. |
| $0 | | $0 | | |
| $0 (Tiers 1,2)<br>$340 (Tiers 3,4,5) | | $0 (Tiers 1,2)<br>$300 (Tiers 3,4,5) | | |
| $6,200 (in-network)<br>$10,000 (combined in- and out-of-network) | | $5,400 (in-network)<br>$10,000 (combined in- and out-of-network) | | The yearly limit on your out-of-pocket costs for hospital or medical services. |
| **In-network** | **Out-of-network** | **In-network** | **Out-of-network** | |
| Days 1-4:<br>$400 / day<br>Days 5+:<br>$0 / day | Days 1+: 50% | Days 1-5:<br>$350 / day<br>Days 6+:<br>$0 / day | Days 1+: 50% | |
| $40 | 50% | $35 | 50% | |
| $325 | 50% | $300 | 50% | |
| $40 | 50% | $35 | 50% | |
| $90 | 50% | $90 | 50% | |
| $400 | 50% | $350 | 50% | |
| $15 | 50% | $10 | 50% | |
| $40 | 50% | $35 | 50% | |

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| | Regence **MedAdvantage Basic (PPO) (no Rx)** | | Regence **MedAdvantage + Rx Primary (PPO)** | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Preventive care** | $0 | 50% | $0 | 50% |
| **Emergency care** | $90 | $90 | $90 | $90 |
| **Urgently needed services** | $40 | $40 | $50 | $50 |
| **Diagnostic services/labs/imaging** | | | | |
| Lab services[1] | $20 | 50% | $30 | 50% |
| Outpatient X-rays | $20 | 50% | $30 | 50% |
| Diagnostic tests and procedures[1] | $20 | 50% | $30 | 50% |
| Diagnostic radiology (MRI, CAT, etc.)[1] | 20% | 50% | 20% | 50% |
| **Hearing services** | | | | |
| Medical hearing exam | $40 | 50% | $50 | 50% |
| Routine hearing exam[2] | $45 | $150 | $45 | $150 |
| Hearing aids (1 per ear, per year)[2] | $699 or $999 per aid | Not covered | $699 or $999 per aid | Not covered |
| **Dental services** | | | | |
| Medical dental services | $40 | 50% | $50 | 50% |
| Preventive dental services[2] | $0 | 50% | Not covered; available as an optional supplemental benefit | Not covered; available as an optional supplemental benefit |
| Comprehensive dental services[2] | Not covered; available as an optional supplemental benefit | Not covered; available as an optional supplemental benefit | Not covered | Not covered |

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

| Regence **MedAdvantage + Rx Classic (PPO)** | | Regence **MedAdvantage + Rx Enhanced (PPO)** | | **What you should know** |
|---|---|---|---|---|
| **In-network** | **Out-of-network** | **In-network** | **Out-of-network** | |
| $0 | 50% | $0 | 50% | |
| $90 | $90 | $90 | $90 | Waived if admitted to the hospital within 48 hours. |
| $40 | $40 | $35 | $35 | |
| $15 | 50% | $10 | 50% | |
| $15 | 50% | $10 | 50% | |
| $15 | 50% | $10 | 50% | |
| 20% | 50% | 20% | 50% | |
| $40 | 50% | $35 | 50% | |
| $45 | $150 | $45 | $150 | You must see a TruHearing® provider for your routine hearing exam to be eligible for in-network coverage. Hearing aids are covered only if obtained from TruHearing. |
| $699 or $999 per aid | Not covered | $599 or $899 per aid | Not covered | |
| $40 | 50% | $35 | 50% | |
| $0 | 50% | $0 | 50% | |
| Not covered; available as an optional supplemental benefit | Not covered; available as an optional supplemental benefit | 50%; $1,000 benefit limit per calendar year | 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.*

| | Regence **MedAdvantage Basic (PPO) (no Rx)** | | Regence **MedAdvantage + Rx Primary (PPO)** | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Vision services** | | | | |
| Medical vision services | $0 | 50% | $0 | 50% |
| Routine vision exam[2] | $0 | 50% | Not covered; available as an optional supplemental benefit | Not covered; available as an optional supplemental benefit |
| Routine vision hardware (one pair of lenses/frames or single purchase of contact lenses per year)[2] | Lenses: $0<br>Frames or contact lenses: Up to $100 allowance | Lenses: 50%<br>Frames or contact lenses: Up to $100 allowance | Not covered; available as an optional supplemental benefit | Not covered; available as an optional supplemental benefit |
| **Mental health services[1]** | | | | |
| Inpatient | Days 1-4: $390 / day<br>Days 5-190: $0 / day | Days 1-190: 50% | Days 1-4: $400 / day<br>Days 5-190: $0 / day | Days 1-190: 50% |
| Outpatient therapy (individual and group) | $40 | 50% | $40 | 50% |
| **Skilled nursing facility[1]** | Days 1-20: $0 / day<br>Days 21-100: $160 / day | Days 1-100: 50% | Days 1-20: $0 / day<br>Days 21-100: $167 / day | Days 1-100: 50% |
| **Physical therapy[1]** | $40 | 50% | $40 | 50% |
| **Ambulance[1]** | $250 | $250 | $275 | $275 |
| **Transportation** | Not covered | Not covered | Not covered | Not covered |
| **Medicare Part B drugs[1]** | 20% | 50% | 20% | 50% |

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| Regence **MedAdvantage + Rx Classic (PPO)** | | Regence **MedAdvantage + Rx Enhanced (PPO)** | | **What you should know** |
|---|---|---|---|---|
| **In-network** | **Out-of-network** | **In-network** | **Out-of-network** | |
| $0 | 50% | $0 | 50% | |
| $0 | 50% | $0 | 50% | You must see a VSP® Vision Care provider for your routine vision exam and hardware to be eligible for in-network coverage. Covered lenses include basic single vision, lined bifocal, lined trifocal or lenticular lenses. |
| Lenses: $0<br>Frames or contact lenses: Up to $100 allowance | Lenses: 50%<br>Frames or contact lenses: Up to $100 allowance | Lenses: $0<br>Frames or contact lenses: Up to $150 allowance | Lenses: 50%<br>Frames or contact lenses: Up to $150 allowance | |
| Days 1-4: $400 / day<br>Days 5-190: $0 / day | Days 1-190: 50% | Days 1-5: $350 / day<br>Days 6-190: $0 / per day | Days 1-190: 50% | |
| $40 | 50% | $35 | 50% | |
| Days 1-20: $0 / day<br>Days 21-100: $167 / day | Days 1-100: 50% | Days 1-20: $0 / day<br>Days 21-100: $160 / day | Days 1-100: 50% | Up to 100 days covered per benefit period. |
| $40 | 50% | $35 | 50% | Includes occupational therapy and speech language therapy. |
| $275 | $275 | $250 | $250 | Copay applies for each one-way transport. |
| Not covered | Not covered | Not covered | Not covered | |
| 20% | 50% | 20% | 50% | Usually administered in a hospital setting, like chemotherapy drugs. |

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| | Regence **MedAdvantage Basic (PPO) (no Rx)** | | Regence **MedAdvantage + Rx Primary (PPO)** | |
|---|---|---|---|---|
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Alternative care**[2] | | | | |
| Acupuncture | $20 | 50% | Not covered | Not covered |
| Chiropractic (routine) | $20 | 50% | $20 | 50% |
| Massage therapy | $20 | 50% | $20 | 50% |
| Naturopathy | $20 | 50% | Not covered | Not covered |
| **Annual physical exam** | $0 | 50% | $0 | 50% |
| **Chiropractic care (Medicare-covered)** | $20 | 50% | $20 | 50% |
| **Fitness membership** | $0 | $0 | $0 | $0 |
| **Meal delivery service**[1,2] | $0 | $0 | $0 | $0 |
| **Telehealth visits** | $20 | 50% | $25 | 50% |

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| Regence **MedAdvantage + Rx Classic (PPO)** | | Regence **MedAdvantage + Rx Enhanced (PPO)** | | **What you should know** |
|---|---|---|---|---|
| **In-network** | **Out-of-network** | **In-network** | **Out-of-network** | |
| $20 | 50% | $20 | 50% | Acupuncture, naturopathy and routine chiropractic have a combined total limit of 18 visits every year. Massage therapy is limited to 6 visits per year. |
| $20 | 50% | $20 | 50% | |
| $20 | 50% | $20 | 50% | |
| $20 | 50% | $20 | 50% | |
| $0 | 50% | $0 | 50% | In addition to the Medicare Annual Wellness Visit. |
| $20 | 50% | $20 | 50% | Limited to manipulation of the spine to correct a subluxation. |
| $0 | $0 | $0 | $0 | Provided by the Silver&Fit® program. |
| $0 | $0 | $0 | $0 | Requires inpatient stay up to 30 days prior; 2 meals per day, 56-meal limit. |
| $15 | 50% | $10 | 50% | Services provided by MDLIVE® or other provider by phone or video chat. |

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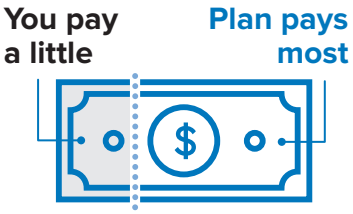
| | Regence **MedAdvantage + Rx Primary (PPO)** | Regence **MedAdvantage + Rx Classic (PPO)** | Regence **MedAdvantage + Rx Enhanced (PPO)** |
|---|---|---|---|
| **Prescription deductible** | $0 (Tiers 1,2)<br>$340 (Tiers 3,4,5) | $0 (Tiers 1,2)<br>$340 (Tiers 3,4,5) | $0 (Tiers 1,2)<br>$300 (Tiers 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 | $3 / $10 |
| Tier 2: Generic | $13 / $20 | $13 / $20 | $8 / $15 |
| Tier 3: Preferred brand | $40 / $47 | $40 / $47 | $40 / $47 |
| Tier 4: Non-preferred drug | 40% / 45% | 40% / 45% | 40% / 45% |
| Tier 5: Specialty | 26% | 26% | 27% |
| **3-month supply** | Preferred retail and mail-order / standard retail | | |
| Tier 1: Preferred generic | $6 / $20 | $6 / $20 | $6 / $20 |
| Tier 2: Generic | $26 / $40 | $26 / $40 | $16 / $30 |
| Tier 3: Preferred brand | $100 / $117.50 | $100 / $117.50 | $100 / $117.50 |
| Tier 4: Non-preferred drug | 40% / 45% | 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% | | |

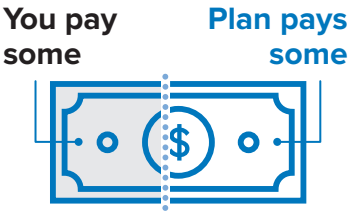
***1-*** *You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy.* ***2-*** *Long-term care facility (31-day supply).*

# Additional prescription information for PPO plans




### Stage 1: Initial coverage phase

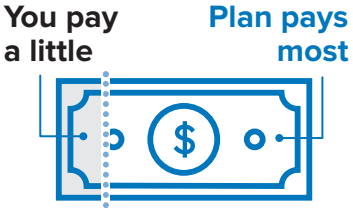
**After you pay your annual deductible** (if your plan has one), you pay a copay or coinsurance for each prescription you fill. Your plan pays the rest. You enter the coverage gap when the total amount you and your plan pay for covered drugs reaches **$4,020.**




### 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.

## Optional supplemental benefits—dental and vision

Optional supplemental benefits are not available for the Regence MedAdvantage + Rx Enhanced plan as it already includes these benefits.

| | Regence **MedAdvantage + Rx Primary (PPO)** | | Regence **MedAdvantage Basic (PPO) (no Rx)** and Regence **MedAdvantage + Rx Classic (PPO)** | |
|---|---|---|---|---|
| **Monthly plan premium** (in addition to your monthly plan and Part B premiums) | $20 | | $25 | |
| | **In-network** | **Out-of-network** | **In-network** | **Out-of-network** |
| **Dental services[2]** | | | | |
| Preventive dental services (exam, X-rays, cleaning, flouride) | $0 | 50% | Included in standard medical benefits | Included in standard medical benefits |
| Comprehensive dental services | Not covered | Not covered | 50%; $1,000 benefit limit per calendar year | 50%; $1,000 benefit limit per calendar year |
| **Vision services[2]** | | | | |
| Routine vision exam | $0 | 50% | Included in standard medical benefits | Included in standard medical benefits |
| Routine vision hardware | Lenses: $0<br>Frames or contact lenses: Up to $100 allowance | Lenses: 50%<br>Frames or contact lenses: Up to $100 allowance | Included in standard medical benefits | Included in standard medical benefits |

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

## Important information to know before you enroll

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

### Understanding the Benefits

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

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

### 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' hódíilnih 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 **1-800-541-8981** (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.

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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).

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