2017 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 Call" from Regence BlueCross BlueShield of Oregon within 7 days of the application receipt.

Enrollment Packet – click links below to download and save documents

Star Rating: HMO / PPO
Apply Online
Download Application: Metro / Non-Metro
Benefit Schedule:
BlueAdvantage (Metro) / BlueAdvantage (Non-Metro) / MedAdvantage Metro / MedAdvantage Non-Metro
Provider Search
Formulary
Multi-language Support: HMO / PPO

Initial Enrollment Period (IEP)

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

Annual Enrollment Period (AEP)

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

Special Enrollment Period (SEP)

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

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

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

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

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613.
Our website: http://www.orhi.us

Regence

January 1, 2017–December 31, 2017

Summary of Benefits

for Clackamas, Lane, Multnomah and Washington counties

This is a summary of drug and health services covered by:

Regence MedAdvantage + Rx Classic (PPO)

Regence MedAdvantage + Rx Enhanced (PPO)

and

Regence MedAdvantage Basic (PPO)

For more information, please call us at the phone number below or visit us at **regence.com/medicare**.

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

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

Hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday (from October 1 through February 14, our telephone hours are from 8:00 a.m. to 8:00 p.m., seven days a week).

H3817_789_001_PPO_2017_SBv2 Accepted

To join **Regence MedAdvantage + Rx Classic (PPO)**, **Regence MedAdvantage + Rx Enhanced (PPO)** or **Regence MedAdvantage Basic (PPO)** 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 Oregon: Clackamas, Lane, Multnomah and Washington.

Regence MedAdvantage + Rx Classic (PPO), **Regence MedAdvantage + Rx Enhanced (PPO)** and **Regence MedAdvantage Basic (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, you may pay more for these services.

Out-of-network/non-contracted providers are under no obligation to treat Regence BlueCross BlueShield of Oregon members, except in emergency situations. If you receive care from an out-of-network/non-contracted provider, we will pay for the same services we cover in-network, as long as the services are medically necessary. For a decision about whether we will cover an out-of-network service, you or your provider can ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see Chapter 4, section 1 of your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Regence MedAdvantage + Rx Classic and **Regence MedAdvantage + Rx Enhanced** cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

Regence MedAdvantage Basic covers Part B drugs such as chemotherapy and some drugs administered by your provider.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" (EOC). You can see our plan's provider directory, pharmacy directory, and the Evidence of Coverage at our website at **regence.com/medicare**.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **regence.com/medicare**.

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

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.

Regence BlueCross BlueShield of Oregon is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/ coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Summary of Benefits January 1, 2017–December 31, 2017

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Monthly Plan Premium	You pay $43	You pay $197	You pay $28	You must continue to pay your Part B premiums.
Deductible	You pay $0 for medical services annually. You pay $240 annually for Part D prescription drugs except Tier 6.	This plan does not have a deductible	This plan does not have a deductible	The deductible is the amount you pay before the plan begins to pay its share of your medical or prescription drug costs.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$6,700 annually for services from in-network providers. $10,000 annually for services from any provider. Services received from in-network providers will count toward this limit.	$5,000 annually for services from in-network providers. $8,300 annually for services from any provider. Services received from in-network providers will count toward this limit.	$6,700 annually for services from in-network providers. $10,000 annually for services from any provider. Services received from in-network providers will count toward this limit.	The most you pay for copays, coinsurance and other costs for covered Part A and Part B medical services for the year. Some services do not apply to the maximum out-of-pocket.
Inpatient Hospital Coverage	**In-network:** You pay a $395 copay per day for days 1 through 4. You pay nothing per day for days 5 through 90. You pay nothing per day for days 91 and beyond. **Out-of-network:** You pay 30% of the cost per day for days 1 and beyond.	**In-network:** You pay a $315 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond. **Out-of-network:** You pay 30% of the cost per day for days 1 and beyond.	**In-network:** You pay a $390 copay per day for days 1 through 4. You pay nothing per day for days 5 through 90. You pay nothing per day for days 91 and beyond. **Out-of-network:** You pay 30% of the cost per day for days 1 and beyond.	Prior authorization is required. Our plan covers an unlimited number of days for an inpatient hospital stay.

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Doctor Visits—Primary	**In-network:** You pay a $10 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $5 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $15 copay **Out-of-network:** You pay 30%	
Doctor Visits—Specialist	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	
Preventive Care	**In-network:** You pay nothing **Out-of-network:** You pay 30%	**In-network:** You pay nothing **Out-of-network:** You pay 30%	**In-network:** You pay nothing **Out-of-network:** You pay 30%	Only preventive services approved by Medicare are covered under this benefit. Any additional preventive services approved by Medicare during the contract year will be covered.
Preventive Care—Annual Physical Exam	**In-network:** You pay nothing **Out-of-network:** You pay 30%	**In-network:** You pay nothing **Out-of-network:** You pay 30%	**In-network:** You pay nothing **Out-of-network:** You pay 30%	This benefit allows 1 physical exam per calendar year in addition to the standard preventive benefits.
Emergency Care	You pay a $75 copay	You pay a $75 copay	You pay a $75 copay	If you are admitted to the hospital within 48 hours for the same condition, you do not have to pay your share of the cost for emergency care. Emergency care is covered worldwide.
Urgently Needed Services	You pay a $50 copay	You pay a $50 copay	You pay a $50 copay	

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Diagnostic Services/ Labs/Imaging				
• Diagnostic Radiology (MRI, CAT, etc.)	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	Prior authorization is required for some services.
• Lab Services	**In-network:** You pay a $10 or $25 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $10 or $25 copay depending on the location **Out-of-network:** You pay 30%	Prior authorization is required for some services.
• Diagnostic Tests and Procedures	**In-network:** You pay a $10 or $25 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $10 or $25 copay depending on the location **Out-of-network:** You pay 30%	Prior authorization is required for some services.
• Outpatient X-rays	**In-network:** You pay a $15 or $30 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 30%	**In-network:** You pay a $5 or $20 copay depending on the location **Out-of-network:** You pay 30%	
Hearing Services— Medical Hearing Exam	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	
Hearing Services— Routine	Not covered	**Routine hearing exam** **In-network:** You pay a $45 copay **Out-of-network:** You pay a $150 copay	Not covered	TruHearing providers must be used for routine hearing services to receive in-network benefits.

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Hearing Services—Routine (cont.)	Not covered	**Hearing aids:** You pay a $599 or $899 copay for each hearing aid, depending on the type.	Not covered	The plan covers 1 hearing aid per ear per calendar year. Coverage and copays for hearing aids apply only to the TruHearing Flyte 700 and Flyte 900 products. Costs for these services do not apply to the maximum out-of-pocket.
Dental Services—Preventive	**In-network:** You pay 50% of the allowed amount **Out-of-network:** You pay 50% of the allowed amount. You are responsible for amounts above the benefit limit.	**In-network:** You pay 50% of the allowed amount **Out-of-network:** You pay 50% of the allowed amount. You are responsible for amounts above the benefit limit.	**In-network:** You pay 50% of the allowed amount **Out-of-network:** You pay 50% of the allowed amount. You are responsible for amounts above the benefit limit.	The plan pays 50% of the allowed amount up to $500 per calendar year. Services covered are: – A full-mouth X-ray every 3 years And every calendar year: – 2 preventive exams – 2 bitewings – 2 cleanings **Out-of-network** dental providers may bill you for any charges remaining over the allowed amount. Costs for these services do not apply to the maximum out-of-pocket.

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Dental Services—Medical	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	
Vision Services—Medical	**Exam to diagnose and treat diseases and conditions of the eye** **In-network:** You pay a $40 copay **Out-of-network:** You pay 30% **Yearly glaucoma screening** **In-network:** You pay nothing **Out-of-network:** You pay 30% **Eyeglasses or contact lenses after cataract surgery** **In-network:** You pay nothing **Out-of-network:** You pay 30%	**Exam to diagnose and treat diseases and conditions of the eye** **In-network:** You pay a $25 copay **Out-of-network:** You pay 30% **Yearly glaucoma screening** **In-network:** You pay nothing **Out-of-network:** You pay 30% **Eyeglasses or contact lenses after cataract surgery** **In-network:** You pay nothing **Out-of-network:** You pay 30%	**Exam to diagnose and treat diseases and conditions of the eye** **In-network:** You pay a $40 copay **Out-of-network:** You pay 30% **Yearly glaucoma screening** **In-network:** You pay nothing **Out-of-network:** You pay 30% **Eyeglasses or contact lenses after cataract surgery** **In-network:** You pay nothing **Out-of-network:** You pay 30%	
Vision Services—Routine Exam	**In-network:** You pay a $40 copay **Out-of-network:** You pay a $40 copay	**In-network:** You pay a $25 copay **Out-of-network:** You pay a $25 copay	**In-network:** You pay a $40 copay **Out-of-network:** You pay a $40 copay	The plan covers 1 exam per calendar year. VSP providers must be used for routine vision care services to receive in-network benefits. **Out-of-network:** VSP will reimburse up to $45 after your copay

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Vision Services—Routine Hardware	**In-network:** **Lenses:** You pay nothing AND **Frames:** You pay nothing up to $100 benefit limit OR **Contact lenses (in lieu of eyeglasses):** You pay nothing up to $100 benefit limit. You are responsible for amounts above the benefit limit. **Out-of-network:** **Lenses and frames:** You pay 100% and may submit a claim for reimbursement OR **Contact lenses:** You pay 100% and may submit a claim for reimbursement. VSP will reimburse up to the amounts listed below for vison hardware: **Single vision lenses:** $30 per pair **Bifocal/ progressive lenses:** $50 per pair **Trifocal lenses:** $65 per pair **Lenticular lenses:** $100 per pair **Frame:** $70	**In-network:** **Lenses:** You pay nothing AND **Frames:** You pay nothing up to $150 benefit limit OR **Contact lenses (in lieu of eyeglasses):** You pay nothing up to $150 benefit limit. You are responsible for amounts above the benefit limit. **Out-of-network:** **Lenses and frames:** You pay 100% and may submit a claim for reimbursement OR **Contact lenses:** You pay 100% and may submit a claim for reimbursement. VSP will reimburse up to the amounts listed below for vison hardware: **Single vision lenses:** $30 per pair **Bifocal/ progressive lenses:** $50 per pair **Trifocal lenses:** $65 per pair **Lenticular lenses:** $100 per pair **Frame:** $70	**In-network:** **Lenses:** You pay nothing AND **Frames:** You pay nothing up to $100 benefit limit OR **Contact lenses (in lieu of eyeglasses):** You pay nothing up to $100 benefit limit. You are responsible for amounts above the benefit limit. **Out-of-network:** **Lenses and frames:** You pay 100% and may submit a claim for reimbursement OR **Contact lenses:** You pay 100% and may submit a claim for reimbursement. VSP will reimburse up to the amounts listed below for vison hardware: **Single vision lenses:** $30 per pair **Bifocal/ progressive lenses:** $50 per pair **Trifocal lenses:** $65 per pair **Lenticular lenses:** $100 per pair **Frame:** $70	VSP providers must be used for routine vision care services to receive in-network benefits. **In-network:** The plan covers 1 set of basic single vision, lined bifocal, lined trifocal, or lenticular lenses per calendar year **AND** 1 set of frames up to the frame benefit limit. Frames and lenses must be purchased in the same visit. **OR** Unlimited contact lenses (in lieu of eyeglasses) up to the benefit limit. Limited to a single purchase per calendar year. Charges for contact lens fittings are applied to the hardware benefit and are subject to the benefit limit. **Out-of-network:** The plan covers 1 set of basic single vision, lined bifocal, or lenticular lenses per calendar year **AND** 1 set of frames. Frames and lenses must be purchased in the same visit.

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Vision Services—Routine Hardware (cont.)	**Elective contact lenses and fitting and evaluation services:** $85 **Contact lenses when you have an eye condition that makes contact lenses necessary:** $210	**Elective contact lenses and fitting and evaluation services:** $105 **Contact lenses when you have an eye condition that makes contact lenses necessary:** $210	**Elective contact lenses and fitting and evaluation services:** $85 **Contact lenses when you have an eye condition that makes contact lenses necessary:** $210	**OR** 1 set of contact lenses per calendar year. Costs for these services do not apply to the maximum out-of-pocket.
Mental Health Services—Inpatient	**In-network:** You pay a $395 copay per day for days 1 through 4. You pay nothing per day for days 5 through 90. **Out-of-network:** You pay 30% of the cost per day for days 1 through 190.	**In-network:** You pay a $315 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. **Out-of-network:** You pay 30% of the cost per day for days 1 through 190.	**In-network:** You pay a $390 copay per day for days 1 through 4. You pay nothing per day for days 5 through 90. **Out-of-network:** You pay 30% of the cost per day for days 1 through 190.	Prior authorization is required.
Mental Health Services—Outpatient (Individual and Group Therapy)	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	Prior authorization is required for some services.
Skilled Nursing Facility	**In-network:** You pay nothing per day for days 1 through 20. You pay a $160 copay per day for days 21 through 100. **Out-of-network:** You pay 30% of the cost per day for days 1 through 100.	**In-network:** You pay nothing per day for days 1 through 20. You pay a $160 copay per day for days 21 through 100. **Out-of-network:** You pay 30% of the cost per day for days 1 through 100.	**In-network:** You pay nothing per day for days 1 through 20. You pay a $160 copay per day for days 21 through 100. **Out-of-network:** You pay 30% of the cost per day for days 1 through 100.	Our plan covers up to 100 days in a skilled nursing facility. Prior authorization is required.
Rehabilitation Services	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	Prior authorization is required for some services.

Premium and Benefits	Regence MedAdvantage + Rx **Classic** (PPO)	Regence MedAdvantage + Rx **Enhanced** (PPO)	Regence MedAdvantage **Basic** (PPO)	**What You Should Know**
Ambulance	You pay a $275 copay per one-way transport	You pay a $250 copay per one-way transport	You pay a $275 copay per one-way transport	Prior authorization is required for some services.
Transportation	Not covered	Not covered	Not covered	
Foot Care (Podiatry Services)	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $25 copay **Out-of-network:** You pay 30%	**In-network:** You pay a $40 copay **Out-of-network:** You pay 30%	
Medical Equipment/ Supplies	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	Prior authorization is required for some services.
Wellness Programs	You pay nothing for our offered wellness programs	You pay nothing for our offered wellness programs	You pay nothing for our offered wellness programs	You have access to the following wellness programs: • The Silver&Fit® Exercise and Healthy Aging Program includes access to fitness facilities and fitness kits to use at home. • Regence Advice24—nurse hotline
Medicare Part B Drugs	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	**In-network:** You pay 20% **Out-of-network:** You pay 30%	Prior authorization is required.

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.

Medicare Part D Prescription Drugs				
(There is no Part D Prescription drug benefit for Regence MedAdvantage Basic)				
	Regence MedAdvantage + Rx **Classic** (PPO)		Regence MedAdvantage + Rx **Enhanced** (PPO)	
Initial Coverage Phase (after you pay your deductible, if applicable)	Retail and mail order 30-day supply	Retail and mail order 90-day supply	Retail and mail order 30-day supply	Retail and mail order 90-day supply
Tier 1: Preferred Generic	You pay $5	You pay $10	You pay $3	You pay $6
Tier 2: Generic	You pay $15	You pay $30	You pay $9	You pay $18
Tier 3: Preferred Brand	You pay $47	You pay $117.50	You pay $47	You pay $117.50
Tier 4: Non-Preferred Drugs	You pay 45%	You pay 45%	You pay 40%	You pay 40%
Tier 5: Specialty Tier	You pay 28%	Not available	You pay 33%	Not available
Tier 6: Select Care Drugs	You pay $0	You pay $0	You pay $0	You pay $0
What You Should Know	A 90-day supply is not available from out-of-network pharmacies or for the Tier 5—Specialty Tier drugs. Cost-sharing may change when you enter another phase of the Part D benefit. For more information on the phases of the benefit, please call us or access our EOC online. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.			

Optional Supplemental Benefits Regence Dental Option		
Monthy Premium	**Comprehensive Dental Benefit**	**What You Should Know**
You pay $28 in addition to your monthly plan and Part B premiums	**In-network:** You pay 50% of the allowed amount for covered services. **Out-of-network:** You pay 50% of the allowed amount for covered services. You are responsible for amounts above the benefit limit.	**In- and out-of-network:** The plan pays 50% of the allowed amount to a limit of $1,000 per calendar year. **Out-of-network** dental providers may bill you for any charges remaining over the allowed amount. Covered services include certain: – Diagnostic services – Restorations, endodontics, periodontics, oral surgery – Crowns, dentures, partials, bridges, implants Costs for these services do not apply to the maximum out-of-pocket. Exclusions apply. See your EOC for more information.

DISCRIMINATION IS AGAINST THE LAW

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, 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, contact our Customer Service at 1-800-541-8981.

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 Appeals and Grievance department by writing us at PO Box 1827 MS: B32AG, Medford, OR 97501, by calling us at 1-866-749-0355, (TTY: 711), by sending a fax to 1-888-309-8784, or by emailing us at medicareappeals@regence.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Appeals and Grievance department is available to help you. 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, available 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

HELP IN OTHER LANGUAGES

The translations on the following pages help people who do not read English know who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-541-8981 (TTY: 711).

Chinese: 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 1-800-541-8981（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-541-8981 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-541-8981 (TTY: 711) 번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-541-8981 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-541-8981 (телетайп: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-541-8981 (ATS : 711).

Japanese: 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。 1-800-541-8981（TTY:711）まで、お電話にてご連絡ください。

Navajo: 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 1-800-541-8981 (TTY: 711).

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-541-8981 (TTY: 711).

Serbo-Croation: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-541-8981 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-541-8981 (TTY: 711)។

Panjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-541-8981 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-541-8981 (TTY: 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-541-8981 (መስማት ለተሳናቸው: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-541-8981 (телетайп: 711).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-541-8981 (टिटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-541-8981 (TTY: 711).

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-541-8981 (TTY: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-541-8981 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-541-8981 (TTY: 711).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-541-8981 (TTY: 711).

Persian (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-541-8981 (TTY: 711) تماس بگیرید.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-541-8981 (رقم هاتف الصم والبكم: 711).

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