

2020 Regence Medicare Advantage Plan Information

Thank you for your interest in applying for the Regence BlueShield of Washington 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 BlueShield within 15 calendar days of receipt of the enrollment request.

Enrollment Packet – click links below to download and save documents

Star Rating: [HMO](#) / [PPO](#)

[Apply Online](#)

Summary of Benefits: [Metro HMO](#) / [Metro PPO](#) / [Non-Metro HMO](#)

Provider Search: [Align & Align Plus HMO](#) / [HMO & HMO Plus](#) / [Primary, Classic & Enhance PPO](#)

[Pharmacy Search](#)

Formulary: [Align HMO](#) / [Align HMO Plus](#) / [HMO](#) / [HMO Plus](#) / [Primary PPO](#) / [Classic PPO](#) / [Enhanced 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: <https://medicare-washington.com>

Y0062_MULTIPLAN_CDA INSURANCE Washington 2020

2020 HMO Summary of Benefits

for King, Kitsap, Pierce and Snohomish counties



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 BlueAdvantage HMO	Regence BlueAdvantage HMO Plus
Monthly plan premium	You must continue to pay your Medicare Part B premium.		
	\$0	\$0	\$48
Deductible			
Medical	\$0	\$0	\$0
Prescription	Not covered	\$0 (Tiers 1,2) \$250 (Tiers 3,4,5)	\$0 (Tiers 1,2) \$200 (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 coverage¹			
	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 center¹			
For wound care	\$45	\$45	\$45
For all other services	\$225	\$300	\$250
Outpatient hospital coverage¹			
For wound care	\$45	\$45	\$45
For observation	\$90	\$90	\$90
For all other services	\$275	\$350	\$300

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. Our service area includes the following counties in Washington: **King, Kitsap, Pierce** and **Snohomish**.

	Regence BlueAdvantage HMO No Rx	Regence BlueAdvantage HMO	Regence BlueAdvantage HMO Plus
Doctor visits			
Primary care visit	\$10	\$15	\$10
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. **3-** Services may require a physician referral.

	Regence BlueAdvantage HMO No Rx	Regence BlueAdvantage HMO	Regence BlueAdvantage HMO Plus
Dental services			
Medical dental exam ³	\$45	\$45	\$45
Preventive dental services (exam, X-rays, cleaning, fluoride) 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 services¹			
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 facility¹			
	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 therapy¹			
	Includes occupational therapy and speech language therapy.		
	\$40	\$40	\$40

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	Regence BlueAdvantage HMO No Rx	Regence BlueAdvantage HMO	Regence BlueAdvantage HMO Plus
Ambulance¹	Copay applies for each one-way transport.		
	\$275	\$275	\$275
Transportation	Not covered		
	Not covered	Not covered	Not covered
Medicare Part B drugs¹	Usually administered in a hospital setting, like chemotherapy drugs.		
	20%	20%	20%
Alternative care²	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	\$20	\$20
Chiropractic (routine)	\$20	\$20	\$20
Massage therapy	\$20	\$20	\$20
Naturopathy	\$20	\$20	\$20
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	\$15	\$10

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	Regence BlueAdvantage HMO Plus
Prescription deductible	\$0 (Tiers 1,2) \$250 (Tiers 3,4,5)	\$0 (Tiers 1,2) \$200 (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%	29%

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

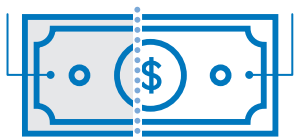
You pay a little Plan pays most



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**.

You pay some Plan pays some



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.

You pay a little Plan pays most



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

Monthly plan premium In addition to your monthly HMO plan and Part B premiums.

\$25

\$20

\$25

Dental services²

Preventive dental services (exam, X-rays, cleaning, fluoride)

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 services²

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](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, 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>.

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, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃសេវាគឺអាចមានសំរាប់អ្នក។ 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 (टिपटिवाइ: 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 فانكر 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. 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 BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

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