Regence

JANUARY 1 – DECEMBER 31, 2018

Summary of Benefits

for the service area of King, Pierce and Snohomish Counties

Summary of drug and health services covered by:

Regence
BlueAdvantage
HMO

Regence
BlueAdvantage
HMO Plus

Are you eligible?

To join **Regence BlueAdvantage HMO** or **Regence BlueAdvantage HMO Plus** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

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
1-855-522-8896 (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).

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.

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

Regence BlueShield is a Medicare Advantage plan with a Medicare contract. Enrollment in Regence BlueShield 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.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Premium, deductible and out-of-pocket limits		
Monthly Plan Premium	You pay $0	You pay $47
	You must continue to pay your Medicare Part B premiums.	
Deductible	This plan does not have a medical deductible. You pay a $405 Part D prescription drug deductible annually. (waived for Tier 6 drugs)	This plan does not have a medical deductible. You pay a $200 Part D prescription drug deductible annually. (waived for Tier 6 drugs)
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	$6,700 annually	$5,900 annually
	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.	
Medical and hospital benefits		
Inpatient Hospital Coverage	You pay a $430 copay per day for days 1 through 4. You pay nothing per day for days 5 and beyond.	You pay a $390 copay per day for days 1 through 4. You pay nothing per day for days 5 and beyond.
	Prior authorization is required for some services. Our plan covers an unlimited number of days for an inpatient hospital stay.	
Outpatient Hospital Coverage		
– Outpatient Hospital Services	You pay 20%	You pay 20%
	Prior authorization is required for some services.	
– Ambulatory Surgical Center Services	You pay 15%	You pay 15%
	Prior authorization is required for some services.	

Using in-network providers

Regence BlueAdvantage HMO and **Regence BlueAdvantage HMO Plus** plans have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services. You must choose a Primary Care Provider (PCP) when you sign up for one of our plans.

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 **regence.com/medicare**.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Doctor Visits		
– Primary Care Provider	You pay a $15 or $45 copay depending on the location	You pay a $10 or $45 copay depending on the location
– Specialist	You pay a $45 copay	You pay a $45 copay
	A referral is required from your in-network PCP for specialist services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
Preventive Care	You pay nothing	You pay nothing
	Only preventive services approved by Medicare are covered under this benefit. If Medicare approves additional preventive services during the contract yeart, those will also be covered. Some of the preventive services are: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screening (colonoscopy, fecal occult blood test, or flexible sigmoidoscopy) Depression screening Diabetes screening HIV screening Medical nutrition therapy services Obesity screening and therapy Prostate cancer screening (PSA) Sexually transmitted infections screening and counseling Some vaccines (including flu, hepatitis B, and pneumococcal shots) Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) “Welcome to Medicare” preventive visit (one-time) Yearly “Wellness” visit	
Emergency Care	You pay an $80 copay	You pay an $80 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 $45 copay	You pay a $45 copay

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Diagnostic Services/Labs/Imaging		
– Diagnostic Radiology (MRI, CAT, etc.)	You pay 20%	You pay 20%
	Prior authorization is required for some services.	
– Lab Services	You pay a $25 or $40 copay depending on the location	You pay a $20 or $35 copay depending on the location
	Prior authorization is required for some services.	
– Diagnostic Tests and Procedures	You pay a $25 or $40 copay depending on the location	You pay a $20 or $35 copay depending on the location
	Prior authorization is required for some services.	
– Outpatient X-rays	You pay a $20 or $35 copay depending on the location	You pay a $20 or $35 copay depending on the location
Hearing Services		
Medical Hearing Exam	You pay a $45 copay	You pay a $45 copay
	A referral is required from your in-network PCP for specialist services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
Dental Services		
– Medical Dental Services	You pay a $45 copay	You pay a $45 copay
	A referral is required from your in-network PCP for specialist services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
– Preventive Dental Services	**Not covered** See the Optional Supplemental Benefits section of this book for preventive dental options available for an additional premium.	You pay nothing. Services covered with in-network dental providers only, and are limited to: A full-mouth X-ray every 3 years, and 2 preventive exams, 2 bitewings, and 2 cleanings every calendar year. Costs for these services do not apply to the maximum out-of-pocket.

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Vision Services		
– Medical Vision Services	You pay nothing.	You pay nothing.
	A referral is required from your in-network PCP for specialist services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
– Routine Vision Exam	**Not covered** See the Optional Supplemental Benefits section of this book for vision options available for an additional premium.	You pay nothing.
	Regence BlueAdvantage HMO Plus covers 1 exam per calendar year. VSP providers must be used for routine vision exams to receive benefits. Costs for these services do not apply to the maximum out-of-pocket.	
– Routine Vision Hardware	**Not covered** See the Optional Supplemental Benefits section of this book for vision options available for an additional premium.	**Lenses:** You pay nothing. AND **Frames:** You pay nothing up to $100 benefit limit. OR **Elective contact lenses (in lieu of eyeglasses):** You pay nothing up to $100 benefit limit. You are responsible for amounts above the benefit limits. **Contact lenses (due to a medically necessary condition):** You pay nothing. Limited to one set per calendar year.
	Regence BlueAdvantage HMO Plus 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 elective 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. VSP providers must be used for routine vision hardware to receive benefits. Costs for these services do not apply to the maximum out-of-pocket.	

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Mental Health Services		
– Inpatient	You pay a $390 copay per day for days 1 through 4 You pay nothing per day for days 5 through 190	You pay a $390 copay per day for days 1 through 4 You pay nothing per day for days 5 through 190
	Prior authorization is required for some services.	
– Outpatient (Individual and group therapy)	You pay a $15 or $40 copay depending on the provider specialty and location	You pay a $10 or $40 copay depending on the provider specialty and location
	Prior authorization is required for some services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
Skilled Nursing Facility	You pay nothing per day for days 1 through 20 You pay a $167 copay per day for days 21 through 100	You pay nothing per day for days 1 through 20 You pay a $167 copay per day for days 21 through 100
	Our plan covers up to 100 days in a skilled nursing facility. Prior authorization is required.	
Physical Therapy (Includes physical therapy, occupational therapy, and speech language therapy)	You pay a $40 copay	You pay a $40 copay
	Prior authorization is required for some services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.	
Ambulance	You pay a $275 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

	Regence **BlueAdvantage HMO**	Regence **BlueAdvantage HMO Plus**
Medical and hospital benefits (cont.)		
Medicare Part B Drugs	You pay 20%	You pay 20%
	Prior authorization is required for some medications.	

Regence BlueAdvantage HMO and **Regence BlueAdvantage HMO Plus** plans cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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

Medicare Part D prescription drugs—initial coverage phase

Regence **BlueAdvantage HMO**

You pay a $405 Part D prescription drug deductible annually (waived for Tier 6 drugs)

Tier	Preferred retail and mail order **30-day supply**	Preferred retail and mail order **90-day supply**	Standard retail **30-day supply**	Standard retail **90-day supply**
1 Preferred Generic	You pay $5	You pay $10	You pay $12	You pay $24
2 Generic	You pay $12	You pay $24	You pay $19	You pay $38
3 Preferred Brand	You pay $40	You pay $100	You pay $47	You pay $117.50
4 Non-Preferred Drugs	You pay 40%	You pay 40%	You pay 45%	You pay 45%
5 Specialty Tier	You pay 25%	Not available	You pay 25%	Not available
6 Select Care Drugs	You pay $0	You pay $0	You pay $3	You pay $6

Regence **BlueAdvantage HMO Plus**

You pay a $200 Part D prescription deductible annually (waived for Tier 6 drugs)

Tier	Preferred retail and mail order **30-day supply**	Preferred retail and mail order **90-day supply**	Standard retail **30-day supply**	Standard retail **90-day supply**
1 Preferred Generic	You pay $5	You pay $10	You pay $12	You pay $24
2 Generic	You pay $12	You pay $24	You pay $19	You pay $38
3 Preferred Brand	You pay $40	You pay $100	You pay $47	You pay $117.50
4 Non-Preferred Drugs	You pay 40%	You pay 40%	You pay 45%	You pay 45%
5 Specialty Tier	You pay 29%	Not available	You pay 29%	Not available
6 Select Care Drugs	You pay $0	You pay $0	You pay $3	You pay $6

A 90-day supply is not available from out-of-network pharmacies or for the Tier 5 — Specialty Tier drugs. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Initial coverage phase

After you pay your annual deductible, 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 $3,750.

Coverage gap

The coverage gap begins after the total yearly drug cost (what you have paid and what our plan has paid) reaches $3,750. After you enter the coverage gap, you pay 35% percent of the plan's cost for covered brand name drugs and 44% percent of the plan's cost for covered generic drugs until your costs total $5,000—which is the end of the coverage gap. Not everyone will enter the coverage gap.

For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.

Catastrophic coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:

- 5% of the cost, or
- $3.35 copay for generic (including brand name drugs treated as generic) and a $8.35 copay for all other drugs

Physical exam

In addition to the annual wellness visit you are eligible for an annual physical exam once every calendar year. You pay nothing for this exam from an in-network provider.

Chiropractic care

Limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):
You pay a $20 copay per visit to an in-network provider.

Case management

Navigating the health care system can be a challenge, but when you're working through a health crisis, not knowing what to do can make things even harder. An advisor from Regence Case Management can help. If you face a serious medical situation, you'll have easy access to one-on-one support at no extra cost. Our staff, including registered nurses and clinical behavioral health specialists, is available to help you make sense of your health coverage and get the care you need.

Disease management

If you're living with a chronic condition, our disease management program can give you the tools and information you need to take an active role in your health.

This program helps you understand how to manage your condition day to day, supports your doctor's plan of care, and helps you improve your quality of life. It also gives you checklists and information to help you figure out how you are doing and general information about your condition. You can get answers about your condition and its treatment over the phone from a registered nurse disease manager. Our nurses use guidelines based on research evidence to decide what education and support might work best for you.

Personalized care support (palliative care)

Get one-on-one support if you or your loved one is facing a serious or life-limiting condition with our Personalized Care Support program. This program uses a team-based approach to coordinate care between medical providers and community resources so that you get the support you need when you need it most.

Urgent and emergency care when you travel

If you travel outside the United States, you can leave home without worrying about access to care if you need it (with the exception of prescription drugs). The plan covers urgent care and medical emergencies anywhere in the world.

Wellness programs

These wellness programs are offered at no cost to you:

– The Silver&Fit® Exercise and Healthy Aging Program includes access to fitness facilities and fitness kits to use at home.
– Regence Advice24 is a 24-hour nurse line staffed by nurses who can help when you are in need of urgent health care advice.

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.

Optional supplemental benefits— dental, vision and hearing benefits for your plan

	DVH option for the **Regence BlueAdvantage HMO** plan	DH option for the **Regence BlueAdvantage HMO Plus** plan
Monthly Premium (In addition to your monthly plan and Part B premiums)	You pay $20	You pay $28
Maximum Out-of-Pocket Responsibility	Costs for optional supplemental benefits do not apply to the maximum out-of-pocket.	
Dental Services		
– Preventive	You pay nothing. Covered services are: A full-mouth X-ray every 3 years and 2 preventive exams, 2 bitewings and 2 cleanings every calendar year.	Included in standard medical benefits.
– Comprehensive	Not covered	You pay 50% of the allowed amount. There is a plan benefit limit of $1,000 per calendar year. You are responsible for amounts above the benefit limit. Covered services include certain: Diagnostic services (problem-focused exams and Intraoral-Periapical films) 2 per calendar year; restorations, endodontics, periodontics, oral surgery, crowns, dentures, partials, bridges and implants.
	Preventive and comprehensive dental services are covered with in-network dental providers only. Services are limited to specific dental codes. Exclusions apply. See the EOC for more information.	
Vision Services		
– Routine Vision Exam	You pay nothing. **Regence BlueAdvantage HMO** covers 1 exam per calendar year. VSP providers must be used for routine vision exams to receive benefits.	Included in standard medical benefits.

Optional supplemental benefits— dental, vision and hearing benefits for your plan

	DVH option for the **Regence BlueAdvantage HMO** plan	DH option for the **Regence BlueAdvantage HMO Plus** plan
Vision Services (cont.)		
– Routine Vision Hardware	**Lenses:** You pay nothing. AND **Frames:** You pay nothing up to $100 benefit limit. OR **Elective contact lenses (in lieu of eyeglasses):** You pay nothing up to $100 benefit limit. You are responsible for amounts above the benefit limits. **Contact lenses (due to a medically necessary condition):** You pay nothing. Limited to one set per calendar year.	Included in standard medical benefits.
	Regence BlueAdvantage HMO 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 elective 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. VSP providers must be used for routine vision hardware to receive benefits.	
Hearing Services		
– Routine Hearing Exam	You pay a $45 copay	You pay a $45 copay
– Hearing Aids	You pay a $699 copay for each TruHearing Flyte Advanced hearing aid. You pay a $999 copay for each TruHearing Flyte Premium hearing aid.	
	The plan covers 1 hearing exam per calendar year. The plan covers 1 hearing aid per ear, per calendar year. TruHearing providers must be used to receive benefits for routine hearing exams and hearing aids. Coverage and copays for hearing aids apply only to the TruHearing Flyte Advanced and Flyte Premium products.	

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'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 ਵਿੱਚਢ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।ਵ

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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 (TTY: 711) 1-888-344-6347 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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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)

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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).

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