Regence MedAdvantage Basic (PPO) offered by Regence BlueCross BlueShield of Oregon

Group Retiree Annual Notice of Changes for 2019

You are currently enrolled as a member of Regence MedAdvantage Basic. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You may make changes to your Medicare coverage for next year during your Annual Enrollment Period.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan
   - If you want to **keep** the Regence MedAdvantage Basic Employer Group plan, you don't need to do anything. You will stay in Regence MedAdvantage Basic.
   - To change to a **different plan** that may better meet your needs:
     - you can switch to a non-group plan at any time.
     - If your group offers multiple plans, you may change to one of those plans during your group's Annual Enrollment Period.

4. **ENROLL:** To change plans, you can join a non-group plan or **change between group-offered plans during your group's Annual Enrollment Period**.
   - If you **don't join another plan** you will stay in Regence MedAdvantage Basic.
   - If you join another plan, your new coverage will start on January 1, 2019 or the first of the month after you send in your enrollment form.

Additional Resources

- Please contact our Customer Service number at 1-888-319-8904 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., Monday through Friday (October 1 through March 31, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week).
- This document is available in an electronic format and may be available in other formats.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Regence MedAdvantage Basic

- Regence BlueCross BlueShield of Oregon is a Medicare Advantage plan with a Medicare Contract. Enrollment in Regence BlueCross BlueShield of Oregon depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Regence BlueCross BlueShield of Oregon. When it says "plan" or "our plan," it means Regence MedAdvantage Basic.
- Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Regence MedAdvantage Basic in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

	2018 (this year)	2019 (next year)
Monthly plan premium **(**See Section 1.1 for details.)	Please contact your benefits/trust office for premium rate information.	Please contact your benefits/trust office for premium rate information.
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $6,700 From in-network and out-of-network providers combined: $10,000	From network providers: $5,700 From in-network and out-of-network providers combined: $10,000
Doctor office visits	**In-network** <u>Primary care visits:</u> You pay a $15 copay per provider per day <u>Specialist visits:</u> You pay a $40 copay per provider per day **Out-of-network** <u>Primary care visits:</u> You pay 50% of the total cost <u>Specialist visits:</u> You pay 50% of the total cost	**In-network** <u>Primary care visits:</u> You pay a $10 copay per provider per day <u>Specialist visits:</u> You pay a $40 copay per provider per day **Out-of-network** <u>Primary care visits:</u> You pay 50% of the allowed amount <u>Specialist visits:</u> You pay 50% of the allowed amount
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network:** You pay a $390 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 and beyond. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $395 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 and beyond. **Out-of-network:** You pay 50% of the allowed amount.

Annual Notice of Changes for 2019
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Please contact your benefits/trust office for premium rate information.	Please contact your benefits/trust office for premium rate information.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount.	$6,700	$5,700 Once you have paid $5,700 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered*:* Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$10,000	There is no change to this out-of-pocket maximum for 2019.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at regence.com/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage*.

Benefit	2018 (this year)	2019 (next year)
Acupuncture	Not covered	**In-network:** You pay a $20 copay per visit. 18 visits per year combined with the Additional Chiropractic and Naturopathy benefits. **Out-of-network:** You pay 50% of the allowed amount. 18 visits per year combined with the Additional Chiropractic and Naturopathy benefits.
Chiropractic services – Additional coverage	Not covered	**In-network:** You pay a $20 copay per visit. 18 visits per year combined with Acupuncture and Naturopathy benefits **Out-of-network:** You pay 50% of the allowed amount. 18 visits per year combined with Acupuncture and Naturopathy benefits.
Emergency care (includes worldwide urgent and emergent coverage)	**In- and out-of-network:** You pay a $75 copay per visit.	**In- and out-of-network:** You pay a $90 copay per visit.

Benefit	2018 (this year)	2019 (next year)
Hearing services – Medicare covered hearing exams	**In-network:** Medicare-covered hearing exams from your PCP: You pay a $15 copay per provider per day in an office setting. You pay a $40 copay per provider per day in a hospital-owned clinic or outpatient setting. Medicare covered hearing exams from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the total cost.	**In-network:** Medicare-covered hearing exams from your PCP: You pay a $10 copay per provider per day Medicare covered hearing exams from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Inpatient hospital care	**In-network:** You pay a $390 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 and beyond. Copays are per admission. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $395 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 and beyond. Copays are per admission. **Out-of-network:** You pay 50% of the allowed amount.
Inpatient mental health care	**In-network:** You pay a $390 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 through 190. Copays are per admission. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $395 copay per day for days 1 – 4. You pay a $0 copay per day for days 5 through 190. Copays are per admission. **Out-of-network:** You pay 50% of the allowed amount.

Benefit	2018 (this year)	2019 (next year)
Medicare diabetes prevention program (MDPP)	**In-network:** You pay a $0 copay per visit **Out-of-network:** You pay 50% of the total cost.	**In-and out-of-network:** You pay a $0 copay per visit
Naturopathy services	Not covered	**In-network:** You pay a $20 copay per visit. 18 visits per year combined with the Additional Chiropractic and Acupuncture benefits. **Out-of-network:** You pay 50% of the allowed amount. 18 visits per year combined with the Additional Chiropractic and Acupuncture benefits.
Outpatient diagnostic lab services	**In-network:** You pay a $10 copay per provider per day at a provider's office or a freestanding lab facility. You pay a $25 copay per provider per day at a hospital or ambulatory surgical center. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $10 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Outpatient diagnostic procedures and tests	**In-network:** You pay a $10 copay per provider per day at a provider's office or a freestanding lab facility. You pay a $25 copay per provider per day at a hospital or ambulatory surgical center. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $10 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.

Benefit	2018 (this year)	2019 (next year)
Outpatient diagnostic X-rays	**In-network:** You pay a $5 copay per provider per day at a provider's office or a freestanding imaging facility. You pay a $20 copay per provider per day at a hospital or ambulatory surgical center. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $10 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Outpatient mental health care (includes individual and group therapy, and psychiatric services)	**In-network:** Outpatient mental healthcare from your PCP: You pay a $15 copay per provider per day in an office setting. You pay a $40 copay per provider per day in a hospital-owned clinic or outpatient setting. Outpatient mental healthcare from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the total cost.	**In-network:** Outpatient mental healthcare from your PCP: You pay a $10 copay per provider per day. Outpatient mental healthcare from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.

Benefit	2018 (this year)	2019 (next year)
Outpatient substance abuse	**In-network:** Outpatient substance abuse care from your PCP: You pay a $15 copay per provider per day in an office setting. You pay a $40 copay per provider per day in a hospital-owned clinic or outpatient setting. Outpatient substance abuse care from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the total cost.	**In-network:** Outpatient substance abuse care from your PCP: You pay a $10 copay per provider per day. Outpatient substance abuse care from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Outpatient surgery – Ambulatory surgical center services	**In-network:** You pay 15% of the total cost per service for facility and professional charges. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $40 copay per visit for certain wound care services. You pay a $225 copay per visit for all other ambulatory surgical center services. You pay a $0 copay for professional services at an ambulatory surgical center. **Out-of-network:** You pay 50% of the allowed amount.

Benefit	2018 (this year)	2019 (next year)
Outpatient surgery – Outpatient hospital services	**In-network:** You pay 20% of the total cost per service for facility and professional charges. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $40 copay per visit for certain wound care services. You pay a $300 copay per visit for all other outpatient hospital services. You pay a $0 copay for professional services at an outpatient hospital. **Out-of-network:** You pay 50% of the allowed amount.
Physician/Practitioner services – Primary care provider services	**In-network:** You pay a $15 copay per provider per day. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $10 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Physician/Practitioner services – Professional services	**In-network:** You pay 15% of the total cost for professional services at an ambulatory surgical center You pay 20% of the total cost for professional services at an outpatient hospital. **Out-of-network:** You pay 50% of the total cost.	**In-network:** You pay a $0 copay for professional services at an ambulatory surgical center. You pay a $0 copay for professional services at an outpatient hospital. **Out-of-network:** You pay 50% of the allowed amount.

Benefit	2018 (this year)	2019 (next year)
Podiatry services	**In-network:** Podiatry services from your PCP: You pay a $15 copay per provider per day in an office setting. You pay a $40 copay per provider per day in a hospital-owned clinic or outpatient setting. Podiatry services from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the total cost.	**In-network:** Podiatry services from your PCP: You pay a $10 copay per provider per day Podiatry services from other Medicare-eligible providers: You pay a $40 copay per provider per day. **Out-of-network:** You pay 50% of the allowed amount.
Virtual diabetes prevention program – Retrofit	Not covered	You pay a $0 copay per session. The Retrofit program must be used to receive this benefit.
Virtual visits	Not covered	**In-network:** You pay a $10 copay per visit. **Out-of-network:** You pay 50% of the allowed amount.
Vision care – Routine vision exam	**In-network:** You pay a $0 copay per exam. **Out-of-network** You pay out -of-pocket and submit for reimbursement up to $45.	**In-network:** You pay a $0 copay per exam. **Out-of-network:** You pay 50% of the billed charges. Out-of-network services may require reimbursement from VSP.

Benefit	2018 (this year)	2019 (next year)
Vision care – Routine vision hardware	**In-network:** Lenses: You pay a $0 copay Frames: $100 benefit maximum Elective contact lenses (in lieu of glasses): $100 benefit maximum Contact Lenses when you have an eye condition that makes contact lenses medically necessary: You pay a $0 copay **Out-of-network:** You pay out -of-pocket and submit for reimbursement up to the amounts listed below for vision 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 each • Elective Contact Lenses and fitting and evaluation services - $85 • Contact Lenses when you have an eye condition that makes contact lenses medically necessary - $210	**In-network:** Lenses: You pay a $0 copay Frames: $100 benefit maximum Elective contact lenses (in lieu of glasses): $100 benefit maximum Contact Lenses when you have an eye condition that makes contact lenses medically necessary: You pay a $0 copay **Out-of-network:** Lenses: You pay 50% of the billed charges. Frames: $100 benefit maximum Elective contact lenses (in lieu of glasses): $100 benefit maximum Contact Lenses when you have an eye condition that makes contact lenses medically necessary: You pay 50% of the billed charges. Out-of-network services may require reimbursement from VSP.

SECTION 2 Administrative Changes

Process	2018 (this year)	2019 (next year)
Annual wellness exam	Covered once every 12 months.	Covered once every calendar year.
Behavioral health services	Prior authorization is required for applied behavior analysis services (treatment of autism).	Prior authorization is **not** required for applied behavior analysis services (treatment of autism).
Diabetic supplies	Prior authorization is required for in-network continuous glucose monitors and related supplies.	Prior authorization is required for in-network continuous glucose monitors and continuous insulin pumps and supplies for both.
Home health services	Prior authorization is **not** required.	Prior authorization **is** required for in-network home health services.
Outpatient observation services	Prior authorization is **not** required.	Prior authorization **is** required for in-network outpatient observation services.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Regence MedAdvantage Basic

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare during the Annual Enrollment Period, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *– OR –* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Regence BlueCross BlueShield of Oregon offers other Medicare health plans *AND/OR* Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Regence MedAdvantage Basic.
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Regence MedAdvantage Basic.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - *– OR –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it during the **Annual Enrollment Period.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage). For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

- In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA)
- In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare The State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

In Oregon, you can call SHIBA at 1-800-722-4134. You can learn more about SHIBA by visiting their website (http://healthcare.oregon.gov/shiba/Pages/index.aspx).

In Washington, you can call SHIBA at 1-800-562-6900. You can learn more about SHIBA by visiting their website (https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Oregon does not have a State Pharmaceutical Assistance Program. Washington has a program called Washington State Health Insurance Pool that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.
    - In Oregon, ADAP is through the CAREAssist Program.
    - In Washington, ADAP is through the Early Intervention Program (EIP).
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.
    - In Oregon, you can call 1-971-673-0144 or visit their website at http://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx.

- In Washington, you can call 1-877-376-9316 or visit their website at https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-971-673-0144 in Oregon or 1-877-376-9316 in Washington.

SECTION 7 Questions?

Section 7.1 – Getting Help from Regence MedAdvantage Basic

Questions? We're here to help. Please call Customer Service at 1-888-319-8904. (TTY only, call 711.) We are available for phone calls 8:00 a.m. to 8:00 p.m., Monday through Friday (October 1 through March 31, our telephone hours are 8:00 a.m. to 8:00 p.m., seven days a week). Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Regence MedAdvantage Basic. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at regence.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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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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' 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 ਵਿੱਚਵ 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 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)