Regence

Regence MedAdvantage + Rx Enhanced (PPO)

2027 Summary of Benefits

January 1, 2027 – December 31, 2027

for residents of Benton County in Oregon and Clark County in Washington

H3817-009-002

For more information

Visit our website at **regence.com/medicare**.

Prospective members call **1-844-734-3623** (TTY: 711) 8 a.m. to 5 p.m., Monday through Friday.

Current members call **1-800-541-8981** (TTY: 711). Customer Service hours are 8 a.m. to 8 p.m., Monday through Friday (October 1 through March 31, our telephone hours are from 8 a.m. to 8 p.m., seven days a week).

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

What you need to know about this book

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, call us and ask for the Evidence of Coverage (EOC). You can also see the EOC on our website, **regence.com/medicare**.

Who can join?

To join Regence MedAdvantage + Rx Enhanced, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes Benton County in Oregon and Clark County in Washington.

Tips for comparing your Medicare benefits

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on Medicare.gov.
- 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 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.

Which doctors, hospitals, and pharmacies can I use?

Regence MedAdvantage + Rx Enhanced has a network of doctors, hospitals, pharmacies, and other providers. With this plan, you have the freedom to enjoy nationwide access to care at in-network costs when you visit any provider participating in the Blue Medicare Advantage PPO Network Sharing Program. Plus, you have the flexibility to visit any provider nationwide who accepts Medicare. You may pay a higher copay or coinsurance when you see an out-of-network provider.

Go to our website at **regence.com/medicare** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

When reviewing the following charts, you'll see the cost differences for in-network vs. out-of-network care and services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Regence MedAdvantage + Rx Enhanced

Plan costs & limits	
Monthly plan premium You must continue to pay your Medicare Part B premium.	$233
Maximum out-of-pocket responsibility Annual limit on your out-of-pocket costs for your Medicare-covered services. This amount does not include prescription drugs. If you reach the limit on out-of-pocket costs, we will pay the full cost for Medicare-covered services for the rest of the year.	$5,900 for services you receive from in-network providers. $9,550 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
Inpatient hospital coverage[1] Our plan covers an unlimited number of days per stay	$300 per day: days 1-5 $0 per day: days 6 and beyond	50%
Outpatient hospital services		
Diagnostic colonoscopy	$0	50%
Wound care services	$30	50%
All other services[1]	20%	50%
Observation services	$400	50%
Ambulatory surgery center services		
Diagnostic colonoscopy	$0	50%
Wound care services	$30	50%
All other services[1]	$300	50%
Doctor visits		
Primary care provider	$0	50%
Virtual primary care provider visits	$0	50%
Specialist	$30	50%
Virtual specialist visits	$25	50%
Preventive care		
Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling	$0	50%

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

Medical benefits	In-network	Out-of-network
Annual wellness visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit Cardiovascular disease testing Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screenings Diabetes screenings HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling Vaccines (flu, pneumonia, COVID-19, Hepatitis B) Welcome to Medicare visit (one-time)		
Annual routine physical exam	$0	50%
Emergency care Your copay is waived if admitted to the hospital within 48 hours. Emergency room visit	$130	$130
Worldwide emergency care	$130	$130
Urgently needed services Urgent care visit	$50	$50
Virtual urgent care visits - through your local care center	$0	$0
Virtual urgent care visits - through our virtual care provider Doctor On Demand	$0	Not covered
Worldwide urgent care visit	$130	$130
Diagnostic services/labs/imaging HbA1C testing	$0	50%

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

Medical benefits	In-network	Out-of-network
Lab services[1]	$10	50%
Outpatient x-rays	$5	50%
Diagnostic tests and procedures[1]	$10	50%
Diagnostic mammography	$0	50%
Diagnostic radiology (MRI, CT, etc.)[1]	$300	50%
Hearing services Exam to diagnose and treat hearing and balance issues	$30	50%
Routine hearing exam[2] - 1 per calendar year, in-network services provided by TruHearing	$0	80%
Hearing aids[2] - 1 per ear per calendar year, in-network hearing aids provided by TruHearing	$499, $699, or $999 per aid	$1,000 deductible, 80%
Dental services Medicare-covered services	$30	50%
Routine dental services - All routine dental services are covered up to a combined benefit maximum every calendar year	$1,500	
Preventive services[2] (Class I) Oral evaluations, 2 per calendar year Routine cleaning or periodontal maintenance, 2 per calendar year, any combination Bitewing x-rays, 1 set per calendar year Full mouth (FMX) or panoramic x-ray, 1 every 3 calendar years Fluoride, 1 per calendar year	$0	50%
Basic comprehensive services[2] (Class II) Periodontal scaling and root planing, 1 each quad every 24 months Restorative fillings, 2 per calendar year Restorative crowns, 1 per calendar year and once per tooth every 5 years	50%	50%
Major comprehensive services[2] (Class III) Dentures (full or partial, new), 1 every 5 years Endodontics (root canals), 1 per calendar year Extractions (including local anesthesia), 2 per calendar year	50%	50%

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

Medical benefits	In-network	Out-of-network
Periodontal full mouth debridement, 1 every 3 years (limit shared with cleanings)		
Vision services		
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0	50%
Routine eye exam[2] - 1 per calendar year, in-network services provided by VSP	$0	50%
Routine eyewear[2] - in-network services provided by VSP		
Lenses - standard basic single-vision, lined bifocal, lined trifocal or lenticular are covered	$0	50%
Frames or contacts - allowance for in- or out-of-network every calendar year	$150	$150
Mental health services		
Inpatient psychiatric hospital[1] - 190-day lifetime maximum	$300 per day: days 1-5 $0 per day: days 6-190	50%: days 1-190
Outpatient mental health[1] - individual or group	$20	50%
Virtual mental health visits - through your provider	$0	50%
Virtual mental health visits - through our virtual care provider Doctor On Demand	$0	Not covered
Skilled nursing facility[1] Up to 100 days covered per benefit period	$10 per day: days 1-20 $218 per day: days 21-44 $0 per day: days 45-100	50%: days 1-100
Outpatient rehabilitation services[1]		
Occupational therapy	$30	50%
Physical and speech language therapy	$30	50%
Virtual outpatient rehabilitation	$30	50%
Ambulance Copay per each one-way Medicare-covered transport		
Ground ambulance	$300	$300
Air ambulance[1]	$300	$300
Worldwide ground or air ambulance	$300	$300

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Medical benefits	In-network	Out-of-network
Transportation	Not covered	Not covered
Medicare Part B drugs[1]		
Chemotherapy drugs	0%-20% (depending on the drug)	50%
Other Part B drugs	0%-20% (depending on the drug)	50%
Part B insulin	20% up to $35	50%
Acupuncture Medicare-covered services only - limited to treatment of chronic low back pain	$20	50%
Chiropractic Medicare-covered services only - limited to manipulation of the spine to correct a subluxation	$15	50%
Diabetic services		
Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or Abbott FreeStyle at a retail pharmacy	$0	50%
Continuous glucose monitor (CGM) and supplies - in-network limited to Dexcom or Abbott FreeStyle Libre	$0	50%
Diabetes self-management training	$0	50%
Lancets, lancet devices, therapeutic shoes, and inserts	$0	50%
Diabetic routine footcare[2] - 6 visits per calendar year	$0	50%
Medicare diabetes prevention program (MDPP)	$0	$0
Fitness program[2] Fitness membership through the Silver&Fit program	$0	80%
Home health agency care[1]	$0	50%
Medical equipment and supplies[1]		
Durable medical equipment	20%	50%
Prosthetics and medical supplies	20%	50%
Outpatient substance use disorder services[1] Individual or group	$20	50%

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

Prescription drugs

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you.

You may pay more than your copay or coinsurance amount if you get drugs from an out-of-network pharmacy. Long-term care facility residents pay the same as at a standard retail pharmacy and are limited to a 31-day supply.

Annual prescription (Part D) deductible stage
$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines

$305 for Tiers 3, 4 and 5

Initial coverage stage
The amount you pay until you have paid $2,400 for covered drugs

Drug tier:	30-day	100-day
Tier 1: Preferred generic		
Standard retail / Standard mail order	$0	$0
Tier 2: Generic		
Standard retail / Standard mail order	$2	$4 / $0
Tier 3: Preferred brand		
Standard retail / Standard mail order	22%	22%
Tier 4: Non-preferred drug		
Standard retail / Standard mail order	32%	32%
Tier 5: Specialty		
Standard retail / Standard mail order	30%	N/A

Catastrophic coverage stage
After your yearly out-of-pocket drug costs reach $2,400, you pay nothing.

Insulin
You won’t pay more than $35 for a 30-day supply or $105 for a 100-day supply for covered insulin products regardless of the cost-sharing tier, even if you haven’t paid your deductible.

Part D vaccine
Our plan covers most adult Part D vaccines at no cost to you, even if you haven’t paid your deductible.

Pre-enrollment checklist

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

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **regence.com/medicare** or call **1-800-541-8981** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

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.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ Benefits, premiums and/or copayments/ coinsurance may change on January 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Disclaimers

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.

Out-of-network/noncontracted providers are under no obligation to treat Plan 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.

You can submit a marketing complaint to us by calling the phone number on the back of your member ID card or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048, 24 hours a day/ 7 days a week. Please reference your agent's name if applicable.

Utilization Management (UM) is the way we review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Clinical professionals make decisions based on our clinical review criteria, guidelines, and medical policies. Examples of UM procedures include pre-service review (prior authorization), concurrent review (including urgent concurrent review) and post-service review. Find more information in our Member FAQ on **regence.com/medicare/resources/faq**.

The Silver&Fit® program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein. Other names and logos may be trademarks of their respective owners.

Doctor On Demand is a separate company that provides telehealth services. Silver&Fit is a separate company that provides wellness and health information services. TruHearing is a separate company that provides discounted hearing products. VSP is a separate company that provides vision services.

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 less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 711

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, D.C. 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 ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi balloojima 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)