Regence Application Packet

Thank you for your interest in applying for the Regence Blue Shield Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form, a link to their online enrollment form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Regence Blue Shield. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Online application Download Policy Outline (.pdf) Download Application (.pdf)

Our website: https://medicare-idaho.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Regence

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

2022 Regence BlueShield of Idaho, Inc. Medicare Supplement (Medigap) Application

Thank you for considering Regence BlueShield of Idaho, Inc. for your health insurance coverage.

Special Notice

- You do not need more than one Medigap policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medigap policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medigap policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medigap policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted if requested within 90 days of losing Medicaid eligibility. If the Medigap policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medigap policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medigap policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medigap policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medigap policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted, if requested within 90 days of losing your employer or union-based group health plan. If the Medigap policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the re-instituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medigap insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB).
- Your rate may change at the Plan's annual renewal date on March 1, so you may initially see an increase before a 12-month period. Rates are guaranteed not to increase for 12 months after the renewal date.
- Except as required by law, we will not accept payments of premium or other cost-sharing obligations on your behalf from a hospital, hospital system, health care provider or other similar individuals or entities that have or will receive financial remuneration related to Your choice of health care. As permitted by the Centers for Medicare and Medicaid Services (CMS), we will accept premium and cost-sharing payments made on your behalf by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations and as directed by the Idaho Department of Insurance pursuant to Bulletin 16-04.

Medigap Enrollment Checklist

Here is an overview of some helpful tips to ensure your enrollment is processed quickly and accurately.
• Answer each required question completely using ink.
• Please include a copy of your Medicare card.
• Be sure to review and complete each applicable section (1–10). – If replacing a Medicare Advantage or Medicare Supplement policy, be sure to complete all fields within section 4. – If selecting EFT billing, be sure to complete all fields within section 7.
• Be sure to sign and date the application in all places indicated. – Signatures or dates that have been altered in any way will not be accepted. – Use the current date when completing the signature date fields of the application. – If you have a power of attorney holder, be sure to provide all legal documentation related to power of attorney. Also, make sure the power of attorney holder signs and dates the application in all signature fields and completes the personal representative fields in section 9.
• Be sure to submit all pages of the application together. – Application should be a legible, full size copy.
• Please provide proof of current or prior coverage. – If you have no current or prior coverage, be sure to complete the health statement located within section 6.* (Please provide specific details to all questions that are answered Yes.) *You do not need to complete the health statement if: a) you turned 65 in the last six months or will turn 65 in the next six months; or b) regardless of age, you enrolled in Medicare Part B in the last six months or will enroll in Medicare Part B in the next six months.
If you need assistance completing this application, please contact our Sales Department at 1-844-Regence (1-844-734-3623) or contact your independent producer.

Section 1: Plan selection

If you are enrolled in Medicare Part A and Part B, you may choose one of the following plans:

☐ Regence Bridge Plan A
☐ Regence Bridge Plan G
☐ Regence Bridge Plan K
☐ Regence Bridge Plan N

If you became Medicare eligible before January 1, 2020 based on disability or ESRD status, OR turned 65 before January 1, 2020 and are currently enrolled in Medicare Part A and Part B, you may be eligible for the following additional plan options:

☐ Regence Bridge Plan C
☐ Regence Bridge Senior Selection (Modified Plan F)

Section 2: Enrollment information

First name, MI		Last name
Gender (M/F)	Birthdate	In the last 12 months have you smoked or used tobacco? ☐ Yes ☐ No

Medicare number _____

Medicare effective dates (from your Medicare card):

Part A (hospital) _____ Part B (physician) _____

I understand that I must be enrolled in Medicare Part A and Part B to be eligible for Medigap coverage. If Medicare Part A and/or Part B terminate for any reason, a Medigap policy is no longer beneficial because Medicare will not be reimbursed.

IDAHO RESIDENCE ADDRESS

To be eligible to apply for our Medigap plans, you must reside in our service area. A photocopy of a valid Idaho state driver's license or identification card and a current utility bill with name and address may be requested as proof of residency.

Residence street address	City, state, ZIP code
Mailing address (if different from residence street address)	City, state, ZIP code

Home phone number	Alternate phone number	Email address

Your application is subject to review and approval by Regence. Complete applications received in our office by midnight Pacific time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested effective date _____

Section 3: Other coverage information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medigap insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medigap plans. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge. (Please mark Yes or No with an "X.")

General Medicare coverage information

A. Did you turn 65 in the last six months?

☐ Yes ☐ No

B. Will you be turning 65 in the next six months?

☐ Yes ☐ No

C. Regardless of age, did you enroll in Medicare Part B in the last six months?

☐ Yes ☐ No

If Yes, what is your effective date for Medicare Part B?

_____

If you answered Yes to A, B, or C, please skip the Health Statement (Section 6).

Please note: Congress has established a six-month open enrollment period for buying Medigap health insurance. The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

Medicaid coverage information

D. Are you covered for medical assistance through the state Medicaid program?

☐ Yes ☐ No

(Note to applicant: If you are participating in a "Spend Down Program" and have not met your "share of cost," please answer No to this question.)

If Yes, will Medicaid pay your rates for this Medigap contract?

☐ Yes ☐ No

If Yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

☐ Yes ☐ No

E. Have you recently lost coverage for medical assistance through the state Medicaid program?

☐ Yes ☐ No

If Yes, what date did coverage end?

_____

Medicare insurance plans

F. Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.

☐ Yes ☐ No

If No, skip to question G.

If Yes: Start _____ End _____

If Yes, with which company and what plan do you have?

_____

If Yes, answer questions a, b and c on the next page.

Please complete Section 4, "Notice to applicant regarding replacement of Medigap insurance or Medicare Advantage."

Section 3: Other coverage information (continued)

Medicare insurance plans (continued)

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap policy?

☐ Yes ☐ No

b. Was this your first time on this type of Medicare plan?

☐ Yes ☐ No

c. Did you voluntarily disenroll from a Medigap policy to enroll in the Medicare plan?

☐ Yes ☐ No

G. Do you have another Medigap policy in force?

☐ Yes ☐ No

If No, skip to question H.

If Yes, with which company and what plan do you have?

_____

If Yes, do you intend to replace your current Medigap policy with this policy?

☐ Yes ☐ No

If Yes, was the effective date of your current policy prior to 6/1/10?

☐ Yes ☐ No

Please complete Section 4, "Notice to applicant regarding replacement of Medigap insurance or Medicare Advantage."

Group or individual insurance coverage

H. Have you had coverage under any other health insurance within the past 63 days? (For example, through an employer, union, or individual plan.)

☐ Yes ☐ No

If No, skip to next section.

If Yes, with which company?

_____

If Yes, what kind of policy?

_____

If Yes, do you intend to replace your current policy with this policy?

☐ Yes ☐ No

If Yes, what are your dates of coverage under the other policy? If you are still covered under this plan, leave "End" blank.

Start _____ End _____

Are you currently enrolled in a Regence medical plan and wish to cancel that coverage?

☐ Yes ☐ No

If Yes, confirm your requested coverage end date: _____

NOTE: If enrolled in a Regence employer group or COBRA plan, you must contact the group administrator to cancel coverage.

Section 4: Notice to applicant regarding replacement of Medigap insurance or Medicare Advantage

Please review this section if you indicated in Section 3 of the application that you intend to terminate existing Medigap coverage or Medicare Advantage insurance, and replace it with a policy to be issued by Regence. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medigap coverage is a wise decision, you should terminate your present Medigap or Medicare Advantage plan. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to applicant by issuer, producer (agent)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medigap policy will not duplicate your existing Medigap coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medigap coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower rates
- ☐ Fewer benefits and lower rates
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ Disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)

- ☐ Other (please specify)

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

_____
Applicant or personal representative's signature

_____
Date of applicant or personal representative's signature

_____
Applicant's name (please print)

_____
Producer signature*

0102279-0009
_____
Producer number

_____
Date of producer's signature

*Producer signature not required if you do not have a producer

Section 5: Medigap protection periods

Do I need to complete a health statement?

When applying for Plan A, C*, Senior Selection (Modified Plan F)*, G, K or N, you do not need to complete a health statement if any of the following is true.

1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area.
2. Your employer group health plan coverage ends.
3. Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medigap policy that covers outpatient prescription medications. Please enclose proof of enrollment in Medicare Part D.
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare.
6. You dropped a Medigap policy to join a Medicare Advantage plan, Medicare Select plan, or PACE program for the first time and now you want to leave. You have been in the plan for less than a year. Note: A health statement is not required if you enroll in the same Medigap policy (with the same company) that you had previously.
7. You leave a Medicare Advantage plan or drop a Medigap plan because the company or its representatives haven't followed the rules or misled you.
8. You lost medical assistance through the state Medicaid program.
9. Beginning on your birthday and for 63 days after your birthday, you terminate an existing Medigap policy and are applying to purchase a comparable or a lesser benefit Medigap policy.**

*If you became Medicare eligible before January 1, 2020 based on disability or ESRD status, OR turned 65 before January 1, 2020 and are currently enrolled in Medicare Part A and Part B, you may be eligible for Plan C or Senior Selection (Modified Plan F).

**If moving to a better benefit policy, a health statement will be required.

Section 6: Health statement

Complete this section if you are not applying during your open enrollment period. Your open enrollment period is the six-month period immediately following your 65th birthday or your enrollment in Medicare Part B. There are other exceptions where you will not need to complete this section. To verify if one of these exceptions applies to you, see page 7, Section 5.

Applicant's height _____ weight _____

In the last 12 months, have you used tobacco or vaped? ☐ Yes ☐ No

A. Within the last five years, have you had diagnosis, treatment, or advice relating to any of the following:

1. Accident, injury, or deformity..... ☐ Yes ☐ No
2. Acquired immune deficiency syndrome (AIDS) or related disease ☐ Yes ☐ No
3. Alcoholism/drug dependency..... ☐ Yes ☐ No
4. Anemia, blood disease, or leukemia ☐ Yes ☐ No
5. Arthritis or rheumatoid arthritis..... ☐ Yes ☐ No
6. Asthma or chronic bronchitis..... ☐ Yes ☐ No
7. Back trouble (recurrent or chronic)... ☐ Yes ☐ No
8. Cancer or tumor..... ☐ Yes ☐ No
9. Confusion or Alzheimer's..... ☐ Yes ☐ No
10. Diabetes..... ☐ Yes ☐ No
11. Dizziness or headaches (fequent).... ☐ Yes ☐ No
12. Epilepsy or convulsions..... ☐ Yes ☐ No
13. Ear, nose, or throat disorders..... ☐ Yes ☐ No
14. Eye disorder, glaucoma..... ☐ Yes ☐ No
15. Female disorders, fibroids, or excessive or irregular bleeding..... ☐ Yes ☐ No
16. Gallbladder..... ☐ Yes ☐ No
17. Heart or circulatory..... ☐ Yes ☐ No
18. High or low blood pressure, or cholesterol..... ☐ Yes ☐ No
19. Intestines, bowel, or colon..... ☐ Yes ☐ No
20. Joint problems, including knee and other..... ☐ Yes ☐ No
21. Kidney or bladder..... ☐ Yes ☐ No
22. Liver disorder or hepatitis..... ☐ Yes ☐ No
23. Lung problems, chronic obstructive pulmonary disease, emphysema, or oxygen use..... ☐ Yes ☐ No
24. Mental anxiety, emotional condition, or depression..... ☐ Yes ☐ No
25. Muscular disorders/dystrophies..... ☐ Yes ☐ No
26. Neurological disease or Parkinson's ☐ Yes ☐ No
27. Neuritis, chronic or recurrent numbness/tingling..... ☐ Yes ☐ No
28. Obesity (overweight)..... ☐ Yes ☐ No
29. Prostate or male disorder..... ☐ Yes ☐ No
30. Rectal disorder, hemorrhoids, or bleeding..... ☐ Yes ☐ No
31. Sciatica or chronic pain..... ☐ Yes ☐ No
32. Skin condition or disease, melanoma ☐ Yes ☐ No
33. Stroke..... ☐ Yes ☐ No
34. Stomach disorders, frequent or chronic heartburn..... ☐ Yes ☐ No
35. Thyroid or glandular..... ☐ Yes ☐ No
36. Ulcer (stomach or duodenal)..... ☐ Yes ☐ No
37. Varicose veins, phlebitis, or blood clots ..... ☐ Yes ☐ No
38. Any other condition or disease not listed above (list below)..... ☐ Yes ☐ No

Section 6: Health statement (continued)

Please explain below any items that you checked "Yes" on the previous page.

Question number	Year	Duration	Disease, injury, or condition	Was recovery complete?	Name of physician

B. In the past three years, have you been advised to have an operation that was not performed? ☐ Yes ☐ No

If Yes, please give full details, including name of physician

C. Have you been hospitalized in the last five years or are you currently hospitalized or in an extended care facility? ☐ Yes ☐ No

If Yes, please explain below (use an extra sheet of paper if necessary).

Date of hospitalization	Disease, injury, or condition	Name of operation performed, if any	Name of physician

D. Are you planning to be hospitalized within the next six months? ☐ Yes ☐ No

If Yes, please explain

E. Have you taken any prescription medications within the past 12 months? ☐ Yes ☐ No

If Yes, please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing physician	Medical condition	Still taking?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section 7: Premium billing options

Billing address (Complete only if billing should be sent to an address other than the mailing address listed on the front of the application.)	
First name	
Last name	
Address	
City	
State	ZIP code
County	
Relationship to applicant	

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to monthly billing).

☐ Monthly

☐ EFT (premium is automatically deducted from your bank account on the 5th of each month)

Note: If selecting EFT, please fill out the information to the right.

EFT information
(complete only if EFT is selected)

Authorization to my bank

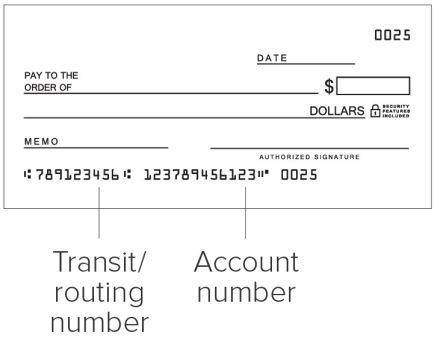
Depending on the timing of your effective date, your first premium payment may have to cover multiple months. If more than one month's premium is due for the first draft, do you authorize Regence to pull the full amount from your account?

☐ Yes ☐ No

If No, you are not eligible for EFT right away. You can enroll in EFT and provide your bank information at a later time.

I (or we, if this is a joint account) authorize Regence to charge my/our bank account for monthly premiums for the below named individual. I also authorize my bank to honor these monthly charges. This authority remains in effect until I revoke it in writing and provide notice to Regence.

Financial institution or bank	
Transit/routing number	
Account number	
Check one: ☐ Checking account ☐ Savings account	
Account holder's name (please print)	
Account holder's signature	**Date**



Section 8: Household discount (if application is approved)

You may receive a premium discount if you qualify for our household discount. Eligibility for a household discount applies when two or more individuals are issued Medigap policies and reside within the same household. List the individual who you reside with that meets the household discount criteria. Signature of the individual is required.

First name	Last name
Signature	Date

Regence will validate household eligibility and may request additional documentation. If you are deemed ineligible for the household discount after the effective date of your coverage, your premium will be adjusted back to your original effective date.

Section 9: Certification, authorization and signature

Be sure to sign and date the following page of the application. Signature applies to both "Certification of completion and correctness" and "Authorization for use and disclosure of protected health information":

Certification of completion and correctness

- I affirm that the answers given in this application are true, complete, and correct.
- I am providing these answers as part of the application procedure required by Regence to enroll in their coverage.
- I understand that Regence will rely on each answer in making coverage and rating determinations.
- I understand that Regence can rescind my policy if additional information changes my eligibility status.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- If coverage is rescinded due to ineligibility, fraud or intentionally misleading statements, Regence will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium.
- I will promptly inform Regence in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect.
- I understand and agree that no coverage shall be in force until approved by Regence. Regence may call me to clarify answers on this application.
- As the applicant, I understand I have the right to inspect the information in my file.
- I will promptly inform Regence if my Medicare eligibility status changes.
- If applying with an insurance producer (agent), I have received the ***Choosing a Medigap Policy***: *A Guide to Health Insurance for People with Medicare* booklet

Authorization for use and disclosure of protected health information

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner
- A clinic, hospital, long-term care or other medical facility
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- An insurance carrier or health plan

Health information requested or disclosed may include, but is not limited to, claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence may deny coverage, modify or cancel coverage and/or take any other legal action available to it by law.

This authorization may not be used for psychotherapy notes (notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session).

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our website at regence.com or by telephone request at 1-800-365-3155.

Section 9: Certification, authorization and signature (continued)

Do you have a personal representative (legal power of attorney/ guardian)? ☐ Yes ☐ No **If yes, complete the following:**	
Personal Representative First Name	Personal Representative Last Name
Relationship to the individual	
Personal Representative's Signature	Date
Please attach legal power of attorney or guardianship documentation if signing as a personal representative.	

If no personal representative, complete the following:	
Signature of Applicant	Date
If additional health information is required to qualify you for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.	

Do not send payment with your application. We will bill you upon acceptance of your application.

Section 10: Insurance producer (agent) certification

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence, and the other services your producer provides you. For more information, please contact your producer.

For producer use only		
I (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the policy except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence and provided the Idaho Disclosure Information required. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.** List any other medical or health insurance policies sold to the applicant		
List the policies still in force		
List the policies sold in the past five years that are no longer in force		
Producer name (please print or type) Tiffany Jackson		
Producer phone number 541-434-9613	Regence producer number 0102279-0009	
Producer signature (required)		Date (required)
Producer: Collect no premium with application.		

Congratulations. You're almost done!
Mail, fax or email this form to Regence BlueShield of Idaho, Inc.

Mail:
P.O. Box 1106, MS-LC1NW
Lewiston, ID 83501-1106

Fax:
1-877-369-3418

Email:
MedigapEligRBS@regence.com

Questions?
Talk to your producer or agent.
Call us at 1-844-REGENCE
(1-844-734-3623).

New to Regence?
You'll receive a letter with your member ID number to get started on regence.com.

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 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 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)