



**Subject: 2025 King County Medicare retiree group plans—see instructions below to enroll**

Thank you for considering Regence Medicare Advantage plans that are available from King County. To enroll in a plan, please follow these three steps:

**Step 1: Review your eligibility and plan options**

To join a Regence Medicare Advantage Retiree Group Plan, you or your Medicare-eligible dependent must be eligible for your former employer's retiree plan, have both Medicare Part A and Medicare Part B and live within the United States or District of Columbia.

Read the enclosed Summary of Benefits for these plans:

- Regence MedAdvantage + Rx Primary (PPO) - **\$19 per month, per enrollee**
- Regence MedAdvantage + Rx Classic (PPO) with Comp Dental - **\$96 per month, per enrollee**  
*\*You must continue to pay your Medicare Part B premium*

**Step 2: Complete your Enrollment Form using one of the following methods:**

- Complete the form fillable application. Sign and date using either digital signature technology or a blue or black ink pen on a printed copy.
- Print and complete the application manually using a blue or black ink pen.

**Step 3: Submit your Enrollment Form using one of the following methods:**

- Mail: Regence MedAdvantage PO Box 1827 Medford, OR 97501
- Fax: 1-888-335-2988 (no cover sheet required)

**Questions?**

Call Regence Customer Service at 1-888-319-8904 (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). Or call your Human Resources department.

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

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.



## Regence MedAdvantage + Rx Primary (PPO) 2025 Summary of Benefits

January 1, 2025 – December 31, 2025

for residents of groups based in Washington

### For more information

Visit our website at [regence.com/mrg](https://regence.com/mrg).

Contact Customer Service at **1-888-319-8904** (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).

## **Who can join?**

To join a Regence Medicare Advantage Retiree Group Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for your employer's retiree plan and live within the United States. As long as you are eligible for your employer's retiree plan, you will have coverage in any state you live in (excluding U.S. territories).

## **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 [www.medicare.gov](http://www.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 [www.medicare.gov](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.

## **Which doctors, hospitals, and pharmacies can I use?**

Regence participates in the Blue Medicare Advantage PPO Network Sharing Program. If you use a Regence MedAdvantage PPO network provider, or any other provider who participates in the PPO Network Sharing Program, you will receive in-network benefits for covered services. If you reside in a county or state that does not participate in the Blue Medicare Advantage PPO Network Program, you will still receive in-network benefits for covered services as long as your chosen provider accepts Medicare. If you choose to use an out-of-network provider when an in-network provider is available, you may pay more for your services, except in urgent and emergency situations.

Go to our website at [\*\*regence.com/mrg\*\*](http://regence.com/mrg) 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 Primary

### Plan costs & limits

<b>Annual deductible</b> The amount you pay for medical services before the plan begins to pay.	\$150
<b>Maximum out-of-pocket responsibility</b> 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.	\$6,700 for services you receive from in-network providers. \$10,100 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
<b>Inpatient hospital coverage<sup>1</sup></b> Our plan covers an unlimited number of days per stay	\$410 per day: days 1-5 \$0 per day: days 6 and beyond	30%
<b>Outpatient hospital services<sup>1</sup></b> Wound care services	\$45	30%
All other services	20%	30%
Observation services	\$400	30%
<b>Ambulatory surgery center services<sup>1</sup></b> Wound care services	\$45	30%
All other services	20%	30%
<b>Doctor visits</b> Primary care provider <sup>3</sup> (deductible waived for in-network only)	\$0	30%
Specialist	\$45	30%
<b>Preventive care<sup>3</sup></b> Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling	\$0	30%

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

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	30%
<b>Emergency care<sup>3</sup></b> Your copay is waived if admitted to the hospital within 48 hours.		
Emergency room visit	\$125	\$125
Worldwide emergency care	\$125	\$125
<b>Urgently needed services<sup>3</sup></b>		
Urgent care visit	\$45	\$45
Virtual urgent care visits - through our virtual care provider Doctor On Demand	\$0	Not covered

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

Medical benefits	In-network	Out-of-network
Worldwide urgent care visit	\$125	\$125
<b>Diagnostic services/labs/imaging</b>		
HbA1C testing <sup>3</sup>	\$0	30%
Lab services <sup>1</sup>	\$25	30%
Outpatient x-rays	\$20	30%
Diagnostic tests and procedures <sup>1</sup>	\$25	30%
Diagnostic mammography <sup>3</sup>	\$0	30%
Diagnostic radiology (MRI, CT, etc.) <sup>1</sup>	\$300	30%
<b>Hearing services</b>		
Exam to diagnose and treat hearing and balance issues	\$45	30%
Routine hearing exam <sup>2,3</sup> - 1 per calendar year, in-network services provided by TruHearing	\$0	\$150
Hearing aids <sup>2,3</sup> - 1 per ear per calendar year, aids must be provided by TruHearing	\$499, \$699, or \$999 per aid	Not covered
<b>Dental services</b>		
Medicare-covered services	\$45	30%
<b>Vision services</b>		
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	\$0	30%
Routine exam <sup>2,3</sup> - 1 per calendar year, in-network services provided by VSP	\$0	30%
Routine eyewear <sup>2,3</sup> - 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	\$100	\$100

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

Medical benefits	In-network	Out-of-network
<b>Mental health services</b>		
Inpatient psychiatric hospital <sup>1</sup> - 190-day lifetime maximum	\$410 per day: days 1-5 \$0 per day: days 6-190	30%: days 1-190
Outpatient mental health <sup>1</sup> - individual or group	\$35	30%
Virtual mental health visits <sup>3</sup> - through our virtual care provider Doctor On Demand	\$0	Not covered
<b>Skilled nursing facility<sup>1</sup></b> Up to 100 days covered per benefit period	\$10 per day: days 1-20 \$214 per day: days 21-52 \$0 per day: days 53-100	30%: days 1-100
<b>Outpatient rehabilitation services<sup>1</sup></b>		
Occupational therapy	\$40	30%
Physical and speech language therapy	\$40	30%
<b>Ambulance<sup>1</sup></b> Copay per each one-way Medicare-covered transport		
Ground ambulance	\$300	\$300
Air ambulance	\$300	\$300
Worldwide ground or air ambulance	\$300	\$300
<b>Transportation</b>	Not covered	Not covered
<b>Medicare Part B drugs<sup>1,3</sup> (<i>deductible waived for in-network only</i>)</b>		
Chemotherapy drugs	0%-20% (depending on the drug)	30%
Other Part B drugs	0% -20% (depending on the drug)	30%
Part B insulin	20% up to \$35	30%

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

Medical benefits	In-network	Out-of-network
<b>Acupuncture</b> Medicare-covered services - limited to treatment of chronic low back pain	\$20	30%
<b>Chiropractic</b> Medicare-covered services - limited to manipulation of the spine to correct a subluxation	\$20	30%
<b>Diabetic services<sup>3</sup></b> Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or LifeScan OneTouch	\$0	50%
Continuous glucose monitor (CGM) and supplies <sup>1</sup> - in-network limited to Dexcom and Abbott FreeStyle Libre	\$0	50%
Diabetes self-management training	\$0	30%
Lancets, lancet devices, therapeutic shoes, and inserts	\$0	50%
Diabetic routine footcare <sup>2</sup> - 6 visits per calendar year	\$0	30%
Medicare diabetes prevention program (MDPP)	\$0	\$0
<b>Durable medical equipment (DME)<sup>1</sup></b>	20%	50%
<b>Fitness program<sup>2,3</sup></b> Fitness membership through the Silver&Fit program	\$0	Not covered
<b>Home delivered meals<sup>2,3</sup></b> Post discharge - 2 meals per day, up to 14 days, 28-meal limit per eligible episode	\$0	Not covered
<b>Outpatient substance use disorder services<sup>1</sup></b> Individual or group	\$35	30%

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## 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.

<b>Annual prescription (Part D) deductible stage</b>	\$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines \$300 for Tiers 3, 4 and 5
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<b>Initial coverage stage</b> (the amount you pay until you have paid \$2,000 for covered drugs)	<b>30-day</b>	<b>up to 100-day</b>
<b>Tier 1: Preferred generic</b>		
Preferred retail / Preferred mail order	\$0	\$0
Standard retail / Standard mail order	\$10	\$20
<b>Tier 2: Generic</b>		
Preferred retail / Preferred mail order	\$13	\$26 / \$0
Standard retail / Standard mail order	\$20	\$40
<b>Tier 3: Preferred brand</b>		
Preferred retail / Preferred mail order	22%	22%
Standard retail / Standard mail order	25%	25%
<b>Tier 4: Non-preferred drug</b>		
Preferred retail / Preferred mail order	40%	40%
Standard retail / Standard mail order	43%	43%
<b>Tier 5: Specialty</b>		
Preferred retail / Preferred mail order	29%	N/A
Standard retail / Standard mail order	29%	N/A

### Catastrophic coverage stage

After your yearly out-of-pocket drug costs reach \$2,000, you pay nothing.

### Supplemental drug coverage

Our plan Tier 1 - Preferred Generics include coverage for prescribed folic acid, vitamin B12, vitamin D and erectile dysfunction drugs. You pay the Initial coverage cost share during the Catastrophic coverage stage.

### Insulin

You won't pay more than \$35 for a 30-day supply or \$87.50 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.



# Regence MedAdvantage + Rx Classic (PPO) with Comp Dental 2025 Summary of Benefits

January 1, 2025 – December 31, 2025

for residents of groups based in Washington

## For more information

Visit our website at [regence.com/mrg](https://regence.com/mrg).

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## **Who can join?**

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## **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 [www.medicare.gov](http://www.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 [www.medicare.gov](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.

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Go to our website at [\*\*regence.com/mrg\*\*](http://regence.com/mrg) 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 Classic with Comp Dental

### Plan costs & limits

<b>Annual deductible</b>	\$0
<b>Maximum out-of-pocket responsibility</b> 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.	\$6,200 for services you receive from in-network providers. \$10,100 for services you receive from in- and out-of-network providers combined.

Medical benefits	In-network	Out-of-network
<b>Inpatient hospital coverage<sup>1</sup></b> Our plan covers an unlimited number of days per stay	\$395 per day: days 1-5 \$0 per day: days 6 and beyond	30%
<b>Outpatient hospital services<sup>1</sup></b> Wound care services	\$35	30%
All other services	15%	30%
Observation services	\$325	30%
<b>Ambulatory surgery center services<sup>1</sup></b> Wound care services	\$35	30%
All other services	15%	30%
<b>Doctor visits</b> Primary care provider	\$0	30%
Specialist	\$35	30%
<b>Preventive care</b> Medicare-covered services: Abdominal aortic aneurysm screening Alcohol misuse screening and counseling Annual wellness visit Bone mass measurement Breast cancer screening (mammogram)	\$0	30%

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

Medical benefits	In-network	Out-of-network
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	30%
<b>Emergency care</b> Your copay is waived if admitted to the hospital within 48 hours.		
Emergency room visit	\$120	\$120
Worldwide emergency care	\$120	\$120
<b>Urgently needed services</b> Urgent care visit	\$40	\$40
Virtual urgent care visits - through our virtual care provider Doctor On Demand	\$0	Not covered
Worldwide urgent care visit	\$120	\$120
<b>Diagnostic services/labs/imaging</b> HbA1C testing	\$0	30%

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 <sup>1</sup>	\$10	30%
Outpatient x-rays	\$10	30%
Diagnostic tests and procedures <sup>1</sup>	\$10	30%
Diagnostic mammography	\$0	30%
Diagnostic radiology (MRI, CT, etc.) <sup>1</sup>	\$250	30%
<b>Hearing services</b>		
Exam to diagnose and treat hearing and balance issues	\$35	30%
Routine hearing exam <sup>2</sup> - 1 per calendar year, in-network services provided by TruHearing	\$0	\$150
Hearing aids <sup>2</sup> - 1 per ear per calendar year, aids must be provided by TruHearing	\$499, \$699, or \$999 per aid	Not covered
<b>Dental services</b>		
Medicare-covered services	\$35	30%
Preventive services <sup>2</sup> (Class I) Oral evaluations, 2 per calendar year Prophylaxis (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 36 months Fluoride, 1 per calendar year	\$0	50%
Basic (Class II) and Major (Class III) comprehensive dental services are covered up to a combined benefit maximum every calendar year	\$1,000	
Basic comprehensive services <sup>2</sup> (Class II) Periodontal scaling and root planing services, 1 per quad every 24 months Restorative fillings, 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
Restorative crowns, 1 per calendar year and once per tooth every 5 years		
Major comprehensive services <sup>2</sup> (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 Periodontal full mouth debridement, 1 every 3 years	50%	50%
<b>Vision services</b>		
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	\$0	30%
Routine exam <sup>2</sup> - 1 per calendar year, in-network services provided by VSP	\$0	30%
Routine eyewear <sup>2</sup> - 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	\$100	\$100
<b>Mental health services</b>		
Inpatient psychiatric hospital <sup>1</sup> - 190-day lifetime maximum	\$395 per day: days 1-5 \$0 per day: days 6-190	30%: days 1-190
Outpatient mental health <sup>1</sup> - individual or group	\$25	30%
Virtual mental health visits - through our virtual care provider Doctor On Demand	\$0	Not covered
<b>Skilled nursing facility<sup>1</sup></b> Up to 100 days covered per benefit period	\$10 per day: days 1-20 \$214 per day: days 21-49 \$0 per day: days 50-100	30%: days 1-100
<b>Outpatient rehabilitation services<sup>1</sup></b> Occupational therapy	\$25	30%

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

Medical benefits	In-network	Out-of-network
Physical and speech language therapy	\$25	30%
<b>Ambulance<sup>1</sup></b> Copay per each one-way Medicare-covered transport		
Ground ambulance	\$275	\$275
Air ambulance	\$275	\$275
Worldwide ground or air ambulance	\$275	\$275
<b>Transportation</b>	Not covered	Not covered
<b>Medicare Part B drugs<sup>1</sup></b> Chemotherapy drugs	0%-20% (depending on the drug)	30%
Other Part B drugs	0% -20% (depending on the drug)	30%
Part B insulin	20% up to \$35	30%
<b>Acupuncture</b> Medicare-covered services - limited to treatment of chronic low back pain	\$20	30%
Additional covered services <sup>2</sup> - combined limit of 15 visits per calendar year with chiropractic	\$30	30%
<b>Chiropractic</b> Medicare-covered services - limited to manipulation of the spine to correct a subluxation	\$20	30%
Additional covered services <sup>2</sup> - combined limit of 15 visits per calendar year with acupuncture	\$30	30%
<b>Naturopathy<sup>2</sup></b> 10 visits per calendar year	\$30	30%

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



Medical benefits	In-network	Out-of-network
<b>Diabetic services</b>		
Diabetic monitoring supplies - in-network supplies limited to Ascensia Contour or LifeScan OneTouch	\$0	50%
Continuous glucose monitor (CGM) and supplies <sup>1</sup> - in-network limited to Dexcom and Abbott FreeStyle Libre	\$0	50%
Diabetes self-management training	\$0	30%
Lancets, lancet devices, therapeutic shoes, and inserts	\$0	50%
Diabetic routine footcare <sup>2</sup> - 6 visits per calendar year	\$0	30%
Medicare diabetes prevention program (MDPP)	\$0	\$0
<b>Durable medical equipment (DME)<sup>1</sup></b>	20%	50%
<b>Fitness program<sup>2</sup></b> Fitness membership through the Silver&Fit program	\$0	Not covered
<b>Home delivered meals<sup>2</sup></b> Post discharge - 2 meals per day, up to 14 days, 28-meal limit per eligible episode	\$0	Not covered
<b>Outpatient substance use disorder services<sup>1</sup></b> Individual or group	\$25	30%
<b>Over the counter (OTC) items and home and bathroom safety devices (Blue FlexDollars™)<sup>2</sup></b> Allowance loaded to a pre-paid benefit card every calendar quarter. Allowance does not roll-over.	\$20	

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.

<b>Annual prescription (Part D) deductible stage</b>	\$0 for Tiers 1 and 2, Tiers 3 and 4 insulins, and most vaccines \$150 for Tiers 3, 4 and 5
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<b>Initial coverage stage</b> (the amount you pay until you have paid \$2,000 for covered drugs)	<b>30-day</b>	<b>up to 100-day</b>
<b>Tier 1: Preferred generic</b>		
Preferred retail / Preferred mail order	\$0	\$0
Standard retail / Standard mail order	\$10	\$20
<b>Tier 2: Generic</b>		
Preferred retail / Preferred mail order	\$13	\$26 / \$0
Standard retail / Standard mail order	\$20	\$40
<b>Tier 3: Preferred brand</b>		
Preferred retail / Preferred mail order	\$40	\$100
Standard retail / Standard mail order	\$47	\$117.50
<b>Tier 4: Non-preferred drug</b>		
Preferred retail / Preferred mail order	40%	40%
Standard retail / Standard mail order	43%	43%
<b>Tier 5: Specialty</b>		
Preferred retail / Preferred mail order	31%	N/A
Standard retail / Standard mail order	31%	N/A

### Catastrophic coverage stage

After your yearly out-of-pocket drug costs reach \$2,000, you pay nothing.

### Supplemental drug coverage

Our plan Tier 1 - Preferred Generics include coverage for prescribed folic acid, vitamin B12, vitamin D and erectile dysfunction drugs. You pay the Initial coverage cost share during the Catastrophic coverage stage.

### Insulin

You won't pay more than \$35 for a 30-day supply or \$87.50 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 **1-888-319-8904**.

### 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. Call **1-888-319-8904** to request 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, 2026.
- ☐ 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 BlueShield serves select counties in the state of Washington and 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](https://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 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.



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**Regence BlueShield  
MedAdvantage (PPO) Enrollment Request Form**

PO Box 1827  
Medford, OR 97501  
1 (888) 319-8904  
TTY 711  
Fax Number: 1 (888) 335-2988

**\*\*Please include ALL pages of the enrollment form when submitting\*\***

**•PLEASE PRINT IN INK•**

**Please provide the following information:**

Employer or Trust Name: **King County Retirees - Direct**

**Please check which plan you want to enroll in:**

- ☐ Regence MedAdvantage + Rx Primary (PPO)
- ☐ Regence MedAdvantage + Rx Classic w/ Comp Dental (PPO)

**Requested Effective Date:**

MM — DD — YYYY

LAST Name		FIRST Name		Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birthdate: (mm/dd/yyyy)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number		Medicare Number (Required)
Permanent Residence Street Address (P.O. Box is not allowed):					
City			State		ZIP Code
Mailing Address (only if different from your Permanent Residence Address): Street Address:					
City			State		ZIP Code
Emergency Contact:			Phone Number:		Relationship to You:
Your e-mail address:					

*By providing your email, you give permission to be contacted about future Medicare news and plan information via email. You may opt out of email communication at any time.*

Employer or Trust Names  
King Co. - Direct

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will be billed directly by Medicare or the Railroad Retirement Board. DO NOT pay Regence MedAdvantage the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your Social Security office, or call Social Security at 1 (800) 772-1213. TTY users should call 1 (800) 325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. **You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month or by having it deducted from your bank account.**

**Please select a premium payment option:**

- ☐ Get a bill (A billing statement will be sent in the mail)
- ☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a preprinted VOIDED check or provide the following:

Account Holder Name: \_\_\_\_\_

If Account Holder name is NOT the name of the applicant on this application, please sign below to authorize deductions: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_ Account Type: ☐ Checking ☐ Savings

*If you don't select a payment option, you will get a bill each month.*

## Please read and answer these important questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Regence MedAdvantage?

Yes ☐ No ☐

If "yes", please list your other coverage:

Name of other coverage \_\_\_\_\_

ID Number for this coverage \_\_\_\_\_

Group Number for this coverage \_\_\_\_\_

2. Do you or your spouse work? ☐ Yes ☐ No

3. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year) \_\_\_\_\_

If no, name of retiree \_\_\_\_\_

4. Are you a resident in a long-term care facility, such as a nursing home? Yes \_\_\_\_ No \_\_\_\_

If "yes" please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street):

\_\_\_\_\_

Please contact Regence MedAdvantage at 1-888-319-8904 (TTY users should call 711) if you need information in another format. Our telephone hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., seven days a week.

**Please choose the name of a Primary Care Physician (PCP), clinic, or health center:**

**First and Last Name of PCP:** \_\_\_\_\_

PCP Address: \_\_\_\_\_

PCP Phone Number: \_\_\_\_\_

**The following questions 1-4 are optional**

**Answering these following 4 questions is your choice. You can't be denied coverage because you don't fill them out.**

1. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |  |
| <input type="checkbox"/> <b>I choose not to answer.</b>                     |  |

2. What's your race? Select all that apply.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Other Asian                      | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> White                  |  |
| <input type="checkbox"/> <b>I choose not to answer.</b>   |   |  |

3. What is your gender: Select one.

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man        | <input type="checkbox"/> <b>I choose not to answer</b> |
| <input type="checkbox"/> Non-binary |  |

4. Which of the following best represents how you think of yourself? Select one.

- |  |  |
|--|--|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, this is, not gay or lesbian | <input type="checkbox"/> I don't know                  |
| <input type="checkbox"/> <b>I choose not to answer</b>         |  |
| <input type="checkbox"/> Bisexual                              |  |



## Please read and sign on page 6

### By completing this enrollment application, I agree to the following:

Regence BlueShield MedAdvantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

Once I am a member of Regence MedAdvantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Regence MedAdvantage when I get it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Regence MedAdvantage coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Regence MedAdvantage provides refunds for all covered benefits, even if I get services out-of-network. Services authorized by Regence MedAdvantage and other services contained in my Regence MedAdvantage Evidence of Coverage document will be covered. Without authorization, NEITHER MEDICARE NOR REGENCE MEDADVANTAGE WILL PAY FOR THE SERVICES.

**Jean Cormier - 000000404100 - 0108394-0001 - 8900632**

Employer or Trust Names  
King Co. - Direct

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Regence MedAdvantage, he/she may be paid based on my enrollment in Regence MedAdvantage.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Regence MedAdvantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give Medicare or their agents the information needed to run the Medicare program. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Regence MedAdvantage or by Medicare.

Your Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_  
month/day/year

\*If you are the authorized representative, you must sign above and provide the following information:

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_  
Plan ID#: \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_  
ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

Regence MedAdvantage is a PPO with a Medicare contract. Enrollment in Regence MedAdvantage depends on contract renewal.

Employer or Trust Names  
King Co. - Direct

## IMPORTANT INFORMATION:

### 2025 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



#### Regence BlueShield - H5009

For 2025, Regence BlueShield - H5009 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★☆☆☆

**Health Services Rating:** ★★☆☆☆

**Drug Services Rating:** ★★☆☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

#### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

#### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

#### Questions about this plan?

Contact Regence BlueShield 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 888-319-8904 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time. Current members please call 888-319-8904 (toll-free) or 711 (TTY).

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

# NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

## **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, sex, sexual orientation or gender identity, 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: 1-800-428-4833

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>

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at  
<https://fortress.wa.gov/oic/online services/cc/pub/complaintinformation.aspx>

## Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' 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 ដោយមិនគិតល្អល 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 ተዘጋጅተዋል፤ የሚከተለው 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)