Regence

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

2022 Clark County Individual Enrollment Application and Change Request Form

Thank you for considering Regence BlueCross BlueShield of Oregon, Inc. for your Individual health insurance coverage. Please complete all sections of this form in black ink. Anything left incomplete may delay your coverage effective date (the day your coverage begins). Applications must be received on or before the 15th of the month in order for coverage to start on the 1st of the following month. We may call you if we have questions about information you provide.

You can apply with this application or save time by shopping for a plan at regence.com.

This application is for health care coverage purchased directly through Regence BlueCross BlueShield of Oregon (Regence). Washington law (RCW 48.43.510) requires an offer of certain health plan information before purchase or selection of a health plan. You can review that information at regence.com or request it from our Customer Service Department by calling 1 (888) 344-6347. Available information concerns benefits, required preauthorization, premiums and cost-sharing, in-network providers, appeals and grievances, accreditation, and confidentiality. If you wish to purchase coverage through the Health Benefit Exchange, you must apply directly through them.

If you need help completing your application or have questions, contact your insurance producer or call us at 1-888-REGENCE.

Section 1: Application type

Check the boxes that apply to you. If you're applying outside of open enrollment, you must have a qualifying event (see Section 3: Qualifying events).

☐ I'm applying to become a new Regence member

☐ I'm a current Regence member (Member ID #: _____) and want to:

- ☐ Change my plan (call us or complete this form).
- ☐ Add a child (complete this form).
- ☐ Add a spouse/domestic partner (complete this form).
- ☐ Cancel my existing medical policy and apply for a new Individual medical plan (call us or complete this form).

  I wish to cancel my current medical policy with Regence on the effective date of my new Individual policy.

  _____
  Signature and date

To change to a new plan, your premium payments must be up to date. If your policy is canceled because your premium wasn't paid, you will need to send us a new application.

I would like coverage to start in the month of _____. We may have to change the start date you request based on your eligibility. Your rates may change depending upon your preferred effective date. Specific special enrollment qualifying events such as birth or adoption require that coverage begins on the date of the event. Coverage is not guaranteed.

Section 2: Eligibility

You can apply for Individual health coverage if you are both:

- A resident of Washington, with a primary residence in Washington for at least 6 months each year.
- Not enrolled in a Medicare plan. Additionally, any dependent enrolled in a Medicare plan will not be eligible for coverage under this Policy. If you're 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.

What about dependents?

You can include these dependents on your Regence plan:

- Your spouse or domestic partner
- Your or your spouse's/domestic partner's children (including children placed with either of you for adoption, or adopted by either of you) under age 26
- Your or your spouse's/domestic partner's disabled children age 26 or over. (We will need a copy of the "Medical Certification of Disability for Disabled Children" form, available on regence.com)

When can you apply?

1. Open enrollment: Every fall, Washington holds open enrollment for individuals applying for coverage to start the following Jan. 1 or thereafter. You can find this year's dates on regence.com. We need to receive your application during open enrollment.
2. Special enrollment: You can apply outside open enrollment if you have a qualifying life event (like a birth or a marriage) that changes your coverage needs. See Section 3 to learn more.

Section 3: Qualifying events

Complete Section 3 if you've had a life event that changes your coverage needs outside the open enrollment period. Check the box next to the situation that applies to you and include the requested documents. You must apply no more than 60 days after the date of the qualifying event.

If you're applying during open enrollment and not due to one of these situations, skip to Section 4.

Date of event: _____ Loss of coverage date (if applicable): _____

(Your qualifying event date may not be the same as your effective date.)

Which of these applies to you?	Include the following:
☐ You have a new dependent(s) through birth, adoption or placement for adoption, or marriage/domestic partnership.	• Copy of birth certificate; adoption or placement papers; or the filed marriage or domestic partnership certification.
☐ You lost coverage due to divorce, legal separation, or termination of domestic partnership.	• Copy of divorce decree or a signed/dated statement of domestic partnership termination. • Certificate of Coverage from the carrier or coverage dates from the employer on company letterhead.
☐ You lost group coverage due to: death of employee; termination of job; reduction in work hours; divorce, legal separation or termination of domestic partnership; Medicare entitlement; loss of dependent child status; or bankruptcy of employer due to Chapter 11 filing.	• Employer letter on company letterhead, Certificate of Coverage or other proof of qualifying event and date of event.
☐ You lost minimum essential coverage as defined in federal law, including, but not limited to, most government-sponsored programs (for example, Medicare, Medicaid, CHIP), employer-sponsored plans, and Individual plans in the state (except due to nonpayment of premium or fraud/intentional material misrepresentation).	• Employer letter on company letterhead, Certificate of Coverage, or other proof of coverage termination reason. If this reason is due to divorce, please provide a copy of the divorce decree.
☐ Your COBRA coverage exhausted.	• A letter from the COBRA administrator or prior insurance company verifying that you exhausted COBRA.
☐ You enrolled or did not receive coverage on a Qualified Health Plan due to an error by the Health Benefit Exchange, the Qualified Health Plan, or Health and Human Services.	• Documentation from the Health Benefit Exchange finding error.
☐ Your Qualified Health Plan violated your contract.	• A copy of the contract showing the provision that was violated. • Proof of the violation.
☐ You're newly eligible or ineligible for advance payment of premium tax credit, or your eligibility for cost-sharing reductions changed.	• Letter from Health and Human Services, the IRS or the Health Benefit Exchange reflecting the change.
☐ Washington State Health Insurance Pool (WSHIP) discontinued your health plan.	• Proof of discontinuation from WSHIP.

Section 3: Qualifying events, continued

Which of these applies to you?	Include the following:
☐ You had a permanent move and: • had minimum essential coverage for at least one day of the 60 days immediately before your move, or • you were living in a foreign country or a U.S. territory immediately before your move	• Proof of coverage or other creditable coverage • A copy of a utility bill in your name from your **prior address** dated within the last 60 days. • Any two documents that show your home address: — A valid picture ID showing your home address: • Washington driver's license • Washington state-issued ID card • Tribal ID card • Military ID card — Utility bill for services received for your current residence (examples: gas, water or electric bill) not older than 60 days. Must include: • date of service • service address • mailing address — Signed rental agreement for current residence (signed by the tenant and landlord) • If you are submitting a month-to-month lease, it must be signed within 60 days of application — Current student enrollment or letter from college/university registrar noting residence address
☐ Your plan is no longer offered to the class of similarly situated persons.	• Proof of change of offer.
☐ You lost coverage because the person you had coverage through lost their coverage (unless the loss was due to fraud or material misrepresentation).	• Certificate of Coverage from the carrier or coverage dates from the employer on company letterhead. • Employer letter on company letterhead with the qualifying event and event date.
☐ Health Benefit Exchange terminated your Qualified Health Plan because of loss of eligibility, permissible rescission, or Qualified Health Plan termination or decertification.	• Certificate of Coverage or proof of other creditable coverage.
☐ Newly gain access to an individual coverage health reimbursement arrangement (ICHRA) or are newly provided a qualified small employer health reimbursement arrangement (QSEHRA).	• Employer letter on company letterhead with confirmation of individual coverage health reimbursement arrangement (ICHRA) election or qualified small employer health reimbursement arrangement (QSEHRA) enrollment, proof that you were not enrolled in the ICHRA or covered by the QSEHRA immediately prior to this new availability and the effective date of the ICHRA participation or QSEHRA policy.

Section 4: Texting application status

Only applicable if the applicant is 18 years or older.
By providing my phone number, I affirmatively consent to receive application status updates via text message.
Phone Number (xxx) xxx-xxxx
Consent is not required as a condition of purchase.
By consenting, you authorize telemarketing through the use of an automatic dialing/texting system or artificial prerecorded message.

Section 5: Child custody information

If coverage will be provided for a child(ren) from a previous marriage or relationship, please indicate below who has custody, and attach a copy of any court or other documentation that shows who is responsible for the child(ren)'s health care expenses or insurance so that we can determine whose coverage is primary. Please use additional paper if needed.

Name of child(ren)	Father	Mother	Joint	Other	Date awarded	Who is required to provide coverage for the child(ren)
	☐	☐	☐	☐		
	☐	☐	☐	☐		

Section 6: Subscriber information (policy holder)

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Residential street address	City	State	ZIP	County
Mailing address (if different from street address)	City	State	ZIP	County
Billing last name	Billing first name		Relationship to applicant	
Billing address (if different from mailing address)	City	State	ZIP	County
Phone number	Alternate number	Email		
Do you spend more than 50% of your time outside of the state of Washington? ☐ Y ☐ N	If yes, indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:			

Will you have other medical and/or dental insurance or Medicare, while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	Policy number	Effective date (mm/dd/yyyy)	Type of coverage
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)

If any enrolling family member has other coverage in addition to Regence, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past six months.

Section 7: Family information

Please list the names of everyone who is eligible who you want to cover. A dependent can be your spouse/domestic partner, children under age 26 or a child of any age who is disabled. If you are applying for coverage for children only, please submit one application per child.

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Spouse ☐ Registered domestic partner ☐ Non-registered domestic partner** ☐ Dependent child under age 26 ☐ Disabled child				
Do you spend more than 50% of your time outside of the state of Washington? ☐ Y ☐ N	If yes, indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:			
Will this person have other medical and/or dental insurance or Medicare while covered on this plan? ☐ Yes (complete the information below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

If any enrolling family member has other coverage in addition to Regence, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past six months.

**Non-registered domestic partners must submit an Affidavit of Domestic Partnership.

Section 7: Family information, continued

Last name	First name	M.I.	Social Security number	Gender
				☐ M ☐ F

Date of birth (mm/dd/yyyy)	Language preference if other than English (optional)	Tobacco user*
	☐ Spanish ☐ Other (please specify)	☐ Y ☐ N

Relationship: ☐ Dependent child under age 26 ☐ Disabled child

Do you spend more than 50% of your time outside of the state of Washington?	If yes, indicate the reason:
☐ Y ☐ N	☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)

Last name	First name	M.I.	Social Security number	Gender
				☐ M ☐ F

Date of birth (mm/dd/yyyy)	Language preference if other than English (optional)	Tobacco user*
	☐ Spanish ☐ Other (please specify)	☐ Y ☐ N

Relationship: ☐ Dependent child under age 26 ☐ Disabled child

Do you spend more than 50% of your time outside of the state of Washington?	If yes, indicate the reason:
☐ Y ☐ N	☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:

Will this person have other medical and/or dental insurance or Medicare while covered on this plan?
☐ Yes (complete the information below) ☐ No

Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)

If any enrolling family member has other coverage in addition to Regence, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past six months.

Section 7: Family information, continued

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Do you spend more than 50% of your time outside of the state of Washington? ☐ Y ☐ N	If yes, indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:			
Will this person have other medical and/or dental insurance or Medicare while covered on this plan? ☐ Yes (complete the information below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

Last name	First name	M.I.	Social Security number	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)	Language preference if other than English (optional) ☐ Spanish ☐ Other (please specify)			Tobacco user* ☐ Y ☐ N
Relationship: ☐ Dependent child under age 26 ☐ Disabled child				
Do you spend more than 50% of your time outside of the state of Washington? ☐ Y ☐ N	If yes, indicate the reason: ☐ Reside ☐ Work ☐ School (provide current registrar information) ☐ Other, please provide reason:			
Will this person have other medical and/or dental insurance or Medicare while covered on this plan? ☐ Yes (complete the information below) ☐ No				
Insurance company	**Policy number**	**Effective date (mm/dd/yyyy)**	**Type of coverage**	
			☐ Employer group ☐ Individual ☐ Medicare ☐ Other (describe)	

If any enrolling family member has other coverage in addition to Regence, we may coordinate benefits between the multiple health plans.

*A tobacco user is someone who has lawfully used tobacco in any form (other than religious or ceremonial use) on average four or more times per week in the past six months.

If you have more dependents, print an additional Page 7 and include it with your application.

Section 8: Plan options

Below are the plan choices available to you based on your county of residence. Check one box to indicate your health plan selection. To learn more about the plans and networks, visit our website: regence.com/go/plans.

Network: PeaceHealth

- ☐ Gold 2500 PeaceHealth
- ☐ Silver HDHP 3000 PeaceHealth
- ☐ Silver 3500 PeaceHealth
- ☐ Silver 6500 PeaceHealth
- ☐ Bronze HDHP 6000 PeaceHealth
- ☐ Bronze Essential 8000 PeaceHealth
- ☐ Bronze Care on Demand 8500 PeaceHealth

Network: Legacy LHP

- ☐ Alliance Gold 2500
- ☐ Alliance Silver HDHP 3000
- ☐ Alliance Silver 3500
- ☐ Alliance Silver 6500
- ☐ Alliance Bronze HDHP 6000
- ☐ Alliance Bronze Essential 8000
- ☐ Alliance Bronze Care on Demand 8500

Optional adult benefits (only available when you also buy a medical plan)

- ☐ Dental and vision

Note: In order to be eligible for the adult dental and vision benefits, you and/or any covered dependents must be 19 or older.

These plans only cover in-network care. This means you will be responsible for 100% of the costs for any out-of-network care (excluding emergency services). Visit regence.com to learn which doctors and hospitals are in each network.

If you selected a High-Deductible Health Plan (HDHP):
The HDHP options are insurance plans which can be paired with a health savings financial account.

To take advantage of the pre-tax savings offered by your HSA financial account from day one, we recommend you open your account by your health plan effective date.

An HDHP option offers its most value when you set up its health savings account (HSA) with a financial institution. You can use our preferred partner, HealthEquity®, or use any other institution.

- ☐ Yes, I authorize Regence to share my eligibility and claims information with HealthEquity for the purposes of establishing and administering my HealthEquity Health Savings Account (Social Security number must be provided in Section 6).

  Terms and conditions of the health savings financial account will be mailed with your HealthEquity HSA Visa Card.

- ☐ No, do not share my information with HealthEquity. I have/will open my own HSA financial account.

Section 9: Payment options

We offer two ways to pay your premium:

☐ Electronic funds transfer (EFT) from a bank account to Regence. Please fill out the EFT authorization agreement. EFT occurs around the fifth of the month and typically takes one or two days to post to your account.

☐ Monthly bill. If you select this option, we'll send you a bill every month.

Is any third-party payer paying for any portion of this policy?

☐ Yes ☐ No

If yes, please indicate payer type and payer name:

☐ Parent/Guardian/Relative
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)/ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ Employer
☐ Other

Indicate payer name:

_____

Are you self-employed, planning to pay your premiums with your business account?

☐ Yes ☐ No

If yes, what is the name of your business?

_____

Note: We do not accept third-party payments from employers, providers and not-for-profit agencies unless required by law.

If you indicate an ICHRA/QSEHRA as a payer, you must pay your premium and request reimbursement from the ICHRA/QSEHRA.

Authorization to my bank

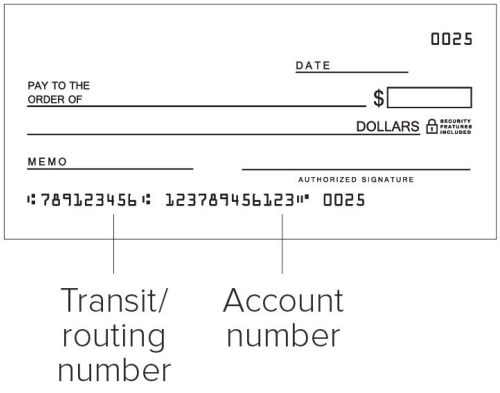
Depending on the timing of your effective date, your first premium payment may have to cover multiple months. If more than one month's premium is due for the first draft, do you authorize Regence to pull the full amount from your account?

☐ Yes ☐ No

If you check "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 checking account for monthly premiums for the below named individual. I/we also authorize my/our bank to honor these monthly charges. This authority remains in effect until I/we 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 10: Signatures

You, your spouse/domestic partner, and children age 18 and older (if applicable) must sign this application. All signatures apply to "Certification of Completion and Correctness" and "Authorization for Use and Disclosure of Protected Health Information."

Certification of Completion and Correctness

- The answers I provided in this application for enrollment are complete and correct.
- I understand that Regence relies on these answers when making coverage and rating decisions.
- It is a crime to knowingly provide false, incomplete or misleading information for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of benefits.
- If coverage is terminated due to fraud or intentionally misleading statements, Regence will reimburse my premiums minus any amount paid for my claims; if the amount Regence has paid in claims is greater than the premiums I paid, I will have to reimburse Regence for the difference.
- I will inform Regence in writing if anything happens before my effective date that makes this application incomplete or incorrect.
- I do not have coverage until Regence approves my application and assigns an effective date.
- Regence may contact me to clarify information in this application.
- I understand that I have the right to inspect the information in my file.
- I understand that if I answered "No" to being a tobacco user and my answer changes to "Yes" any time after submitting this application, I must notify Regence. A surcharge will be applied.*
- If applicable, Regence has permission to contact any employer, plan, or carrier regarding any details related to an assertion of special enrollment rights.

Authorization for Use and Disclosure of Protected Health Information

I understand that Regence may request or disclose health information about me or my covered dependents for the purpose of facilitating health care, payments or benefit administration, or as required by law.

This health information may be related to treatment or services performed by:

- A doctor, 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
- Another insurance carrier or health plan

Health information may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, lab reports, dental records, or hospital records (including nursing records and progress notes). This authorization may not be used for psychotherapy notes; such notes will require a separate authorization.

For more information, please see the Regence Consumer Privacy Notice available at regence.com or by calling 1-888-REGENCE.

* A surcharge is applied to your premium for each person covered by your plan who uses tobacco. If we receive false information about tobacco usage or if you fail to notify Regence of a change in tobacco usage, Regence can collect unpaid surcharges and take any other available action.

Section 10: Signatures, continued

If child-only subscriber under the age of 18, complete this section.	
Print name of responsible party	
Signature of responsible party	Date
Relationship ☐ Parent ☐ Power of Attorney* ☐ Legal Guardian*	
If adult subscriber age 18 and over and applying to Individual or family coverage, complete this section. If signing as a personal representative, please skip to the next section.	
Signature of subscriber	Date
Signature of legal spouse or eligible domestic partner	Date
NOTE: Parent can't sign on behalf of the dependents	
Signature of dependent age 18 or over	Date
Signature of dependent age 18 or over	Date
Signature of dependent age 18 or over	Date
Signature of dependent age 18 or over	Date
If personal representative* for an applicant age 18 and over, complete this section.	
Who are you signing for?	
Print name of responsible party	
Signature of responsible party	Date
Relationship ☐ Parent ☐ Power of Attorney ☐ Legal Guardian	

*Please send legal documentation proving relationship

Section 11: Comments

Please explain any unique circumstances that may affect your application or provide your thoughts on how we can serve you better.

Section 12: 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 contract except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence. **I certify that the information supplied to me by the applicant has been truly and accurately recorded here.**

Name (please print or type)	Regence producer number	
KAREN KANE	0100490-0001	
Mailing address	**Email**	**Phone number**
PO Box 20185 Portland, Oregon 97294	karen@insurancesolutionsnw.com	503-789-7217

DocuSigned by:
KAREN KANE
142D67351F8D446...

Congratulations you're almost done!

Mail, fax or email this form to Regence BlueCross BlueShield of Oregon.

Mail:

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

Fax:

1-877-369-3410

Email:

IndElig@regence.com

Questions?

Talk to your producer. Call us at 1-888-REGENCE (1-888-734-3623).

New to Regence?

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

Regence may provide producers with bonuses, commissions, administrative fees or other compensation (including non-cash compensation). Incentives may be based on such factors as the product you buy, the producer's volume of business with Regence, and other services. These incentives may have an indirect impact on your rates. Please talk to your producer to learn more.

Regence BlueCross BlueShield of Oregon (Clark County, Washington) Broker Commission Disclosure

If you purchased your health insurance coverage using an insurance broker, the below commission schedule discloses the commission amount Regence paid to your broker. The commission is paid on a per-enrolled individual basis for each month that the individual is enrolled with Regence. The commission schedule lists both the monthly and annual commission amounts your broker would receive over the course of one year for each individual enrolled on your health insurance plan.

Regence BlueCross BlueShield of Oregon – residents of Clark County, Washington – Final Commissions for 2022 enrolled Individuals

Open Enrollment (OE) and Special Enrollment Period (SEP)

Coverage	Monthly commission per each enrolled member	Annual commission per each enrolled member (monthly amount x 12)
Regence Medical	$20.00	$240.00
Regence Dental	$2.00	$24.00

* There is a commission cap applied to enrolled individuals up to 20 years of age that limits commission payment to a maximum of three such individuals. There is no commission cap for enrolled dependents between 21-25 years of age.

In addition to the above commission schedule, your broker may receive additional compensation from Regence based on the overall number of individuals who purchase health insurance coverage from Regence through your broker. Those additional payments can vary from $20 per enrolled individual to $28 per enrolled individual depending on the total number of individuals who purchase health insurance coverage from Regence through your broker.

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, gender identity or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

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, sex, gender identity or sexual orientation, 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.

- 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/onlineservices/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'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)