Regence

JANUARY 1 – DECEMBER 31, 2018

Summary of Benefits

for Oregon and Clark County in Washington

Summary of drug and health services covered by:

Regence **MedAdvantage** + **Rx Enhanced** (PPO)

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, please request the "Evidence of Coverage" (EOC). You can see our plan's Evidence of Coverage at our website **regence.com/medicare**.

Are you eligible?

To join **MedAdvantage + Rx Enhanced (PPO)** you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Be eligible for your employer's retiree plan
- Live within the United States

Using in-network providers

Regence MedAdvantage + Rx Enhanced (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, you may pay more for these services.

Regence also participates in the Blue Medicare Advantage PPO Network Sharing Program. The Blue Medicare Advantage Network Sharing Program is available in select areas of 35 states and Puerto Rico: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin.

Accessing your benefits where you live

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).

If you use a Regence MedAdvantage PPO network provider, or a provider who participates in the Blue Medicare Advantage PPO Network Sharing Program, you will receive in-network benefits for covered services. If you live in a state that participates in the Blue Medicare Advantage PPO Network Sharing Program, but you do not have access to in-network providers due to distance, or if you live in a state that does not participate in the Blue Medicare Advantage PPO Network Sharing program, you will receive in-network benefits for covered services. For questions about your coverage where you live contact Customer Service at 1-888-319-8904.

Accessing your benefits when you travel

If you travel outside the state where you live, or the United States, you can leave home without worrying about access to care if you need it.

- Within the United States you will receive in-network benefits when you use a Blue Medicare Advantage PPO Network Sharing program provider. You will receive out-of-network benefits with any other provider, except in urgent or emergent situations.
- Outside of the United States, the plan covers urgent care and medical emergencies anywhere in the world (with the exception of prescription drugs).

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 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.

This document is available electronically and may be available in other formats.
Regence BlueCross BlueShield of Oregon is a Medicare Advantage plan with a Medicare contract. Enrollment in Regence BlueCross BlueShield of Oregon depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Premium, deductible and out-of-pocket limits

Monthly Plan Premium	Contact your group/benefits administrator for premium information.
	You must continue to pay your Medicare Part B premiums.
Deductible	This plan does not have a medical or Part D prescription drug deductible.
	The deductible is the amount you pay before the plan begins to pay its share of your medical or prescription drug costs.
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	$5,000 annually for services from in-network providers. $8,300 annually for services from any provider. Services received from in-network providers will count toward this limit.
	This is the most you pay for copays, coinsurance and other costs for covered Part A and Part B medical services for the year. Some services do not apply to the maximum out-of-pocket.

Finding in-network providers

You can search for a participating Regence MedAdvantage PPO network provider at **regence.com/medicare**, or for a Blue Medicare Advantage PPO Network Sharing Provider at bcbs.com.

Using out-of-network providers

Out-of-network/non-contracted providers are under no obligation to treat Regence members, except in emergency situations. If you receive care from an out-of-network/non-contracted provider, we will pay for the same services we cover in-network, as long as the services are medically necessary. For a decision about whether we will cover an out-of-network service, you or your provider can ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see Chapter 4, section 1 of your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Medical and hospital benefits

Inpatient Hospital Coverage	**In-network:** You pay a $315 copay per day for days 1 through 5. You pay nothing per day for days 6 and beyond. **Out-of-network:** You pay 50% of the cost per day for days 1 and beyond.
	Prior authorization is required for some services. Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	
– Outpatient Hospital Services	**In-network:** You pay 20% **Out-of-network:** You pay 50%
	Prior authorization is required for some services.
– Ambulatory Surgical Center Services	**In-network:** You pay 15% **Out-of-network:** You pay 50%
	Prior authorization is required for some services.
Doctor Visits	
– Primary Care Provider	**In-network:** You pay a $5 or $25 copay depending on the location **Out-of-network:** You pay 50%
– Specialist	**In-network:** You pay a $25 copay **Out-of-network:** You pay 50%
	Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.

Medical and hospital benefits (cont.)

Preventive Care

In-network: You pay a $0 copay

Out-of-network: You pay 50%

Only preventive services approved by Medicare are covered under this benefit. If Medicare approves additional preventive services during the contract year, those will also be covered. Some of the preventive services are:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening (colonoscopy, fecal occult blood test, or flexible sigmoidoscopy)
- Depression screening
- Diabetes screening
- HIV screening
- Medical nutrition therapy services
- Obesity screening and therapy
- Prostate cancer screening (PSA)
- Sexually transmitted infections screening and counseling
- Some vaccines (including flu, hepatitis B, and pneumococcal shots)
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- “Welcome to Medicare” preventive visit (one-time)
- Yearly “Wellness” visit

Emergency Care

You pay a $75 copay

If you are admitted to the hospital within 48 hours for the same condition, you do not have to pay your share of the cost for emergency care.

Urgently Needed Services

You pay a $25 copay

Medical and hospital benefits (cont.)

Diagnostic Services/Labs/Imaging	
– Diagnostic Radiology (MRI, CAT, etc.)	**In-network:** You pay 20% **Out-of-network:** You pay 50%
	Prior authorization is required for some services.
– Lab Services	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 50%
	Prior authorization is required for some services.
– Diagnostic Tests and Procedures	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 50%
	Prior authorization is required for some services.
– Outpatient X-rays	**In-network:** You pay a $0 or $15 copay depending on the location **Out-of-network:** You pay 50%
Hearing Services	
– Medical Hearing Exam	**In-network:** You pay a $25 copay **Out-of-network:** You pay 50%
	Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
– Routine Hearing Exam	**In-network:** You pay a $45 copay **Out-of-network:** You pay a $150 copay
– Hearing Aids	You pay a $599 or $899 copay for each hearing aid, depending on the type.
	Regence MedAdvantage + Rx Enhanced covers 1 hearing exam per calendar year. The plan covers 1 hearing aid per ear, per calendar year. TruHearing providers must be used to receive in-network benefits for routine hearing exams and hearing aids. Coverage and copays for hearing aids apply only to the TruHearing Flyte Advanced and Flyte Premium products. Costs for these services do not apply to the maximum out-of-pocket.

Medical and hospital benefits (cont.)

Dental Services	
– Medical Dental Services	**In-network:** You pay a $25 copay **Out-of-network:** You pay 50%
	Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
– Preventive Dental Services	**In-network:** You pay nothing **Out-of-network:** You pay 50% of the allowed amount
	Services covered are: A full-mouth X-ray every 3 years, and 2 preventive exams, 2 bitewings and 2 cleanings every calendar year. Out-of-network dental providers may bill you for any charges remaining over the allowed amount. Costs for these services do not apply to the maximum out-of-pocket.

Medical and hospital benefits (cont.)

Vision Services	
– Medical Vision Services	**In-network:** You pay nothing **Out-of-network:** You pay 50%
	Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
– Routine Vision Exam	**In-network:** You pay nothing **Out-of-network:** You pay 100% and may submit a claim for reimbursement. VSP will reimburse up to $45.
	The plan covers 1 exam per calendar year. You must use VSP providers for routine vision exams to receive in-network benefits. Costs for these services do not apply to the maximum out-of-pocket.
– Routine Vision Hardware	**In-network: Lenses:** You pay nothing AND **Frames:** You pay nothing up to $150 benefit limit OR **Elective contact lenses (in lieu of eyeglasses):** You pay nothing up to $150 benefit limit. You are responsible for amounts above the benefit limits. **Contact lenses (due to a medically necessary condition):** You pay nothing. Limited to one set per calendar year.
	Out-of-network: You pay 100% for lenses and frames, or elective contact lenses in lieu of glasses, and may submit a claim for reimbursement. VSP will reimburse up to the following amounts for vision hardware: **For elective contact lenses and fitting and evaluation services** VSP will reimburse up to $105. For all other hardware for all plans VSP will reimburse up to: **Single-vision lenses:** $30 per pair **Bifocal/progressive lenses:** $50 per pair **Trifocal lenses:** $65 per pair **Lenticular lenses:** $100 per pair **Frame:** $70 **Contact lenses** when you have an eye condition that makes contact lenses necessary: $210

Medical and hospital benefits (cont.)

Vision Services (cont.)	
– Routine Hardware (cont.)	The plan covers 1 set of basic single vision, lined bifocal, lined trifocal or lenticular lenses per calendar year, AND 1 set of frames up to the frame benefit limit. Frames and lenses must be purchased in the same visit. OR Unlimited elective contact lenses (in lieu of eyeglasses) up to the benefit limit. Limited to a single purchase per calendar year. Charges for contact lens fittings are applied to the hardware benefit and are subject to the benefit limit. VSP providers must be used for routine vision hardware to receive in-network benefits. Costs for these services do not apply to the maximum out-of-pocket.
Mental Health Services	
– Inpatient Services	**In-network:** You pay a $315 copay per day for days 1 through 5. You pay nothing per day for days 6 through 190. **Out-of-network:** You pay 50% of the cost per day for days 1 through 190. Prior authorization is required for some services.
– Outpatient Services (Individual and group therapy)	**In-network:** You pay a $25 copay **Out-of-network:** You pay 50% Prior authorization is required for some services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
Skilled Nursing Facility	**In-network:** You pay nothing per day for days 1 through 20. You pay a $160 copay per day for days 21 through 100. **Out-of-network:** You pay 50% of the cost per day for days 1 through 100. Our plan covers up to 100 days in a skilled nursing facility. Prior authorization is required.

Medical and hospital benefits (cont.)

Physical Therapy (Includes physical therapy, occupational therapy and speech language therapy)	**In-network:** You pay a $25 copay **Out-of-network:** You pay 50%
	Prior authorization is required for some services. Services rendered in a hospital-owned clinic or in an outpatient hospital may have associated facility charges. See the Outpatient Hospital Services section for cost-sharing amounts.
Ambulance	You pay a $250 copay per one-way transport
	Prior authorization is required for some services.
Transportation	Not covered
Medicare Part B Drugs	**In-network:** You pay 20% **Out-of-network:** You pay 50%
	Prior authorization is required for some services.

Regence MedAdvantage + Rx Enhanced covers Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of covered drugs) and any restrictions on our website **regence.com/medicare**.

Medicare Part D prescription drugs—initial coverage phase

Regence **MedAdvantage + Rx Enhanced** (PPO)

This plan does not have a Part D prescription drug deductible

Tier	Preferred retail and mail order **30-day supply**	Preferred retail and mail order **90-day supply**	Standard retail **30-day supply**	Standard retail **90-day supply**
1 Preferred Generic	You pay $3	You pay $6	You pay $10	You pay $20
2 Generic	You pay $8	You pay $16	You pay $15	You pay $30
3 Preferred Brand	You pay $40	You pay $100	You pay $47	You pay $117.50
4 Non-Preferred Drugs	You pay 40%	You pay 40%	You pay 45%	You pay 45%
5 Specialty Tier	You pay 33%	Not available	You pay 33%	Not available
6 Select Care Drugs	You pay $0	You pay $0	You pay $3	You pay $6
	A 90-day supply is not available from out-of-network pharmacies or for the Tier 5 — Specialty Tier drugs. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.			

Initial coverage phase

After you pay your annual deductible (if your plan has one), you pay a copay or coinsurance for each prescription you fill. Your plan pays the rest. You enter the coverage gap when the total amount you and your plan pay for covered drugs reaches $3,750.

Coverage gap

The coverage gap begins after the total yearly drug cost (what you have paid and what our plan has paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000—which is the end of the coverage gap. Not everyone will enter the coverage gap.

For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.

Catastrophic coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:

- 5% of the cost, or
- $3.35 copay for generic (including brand name drugs treated as generic) and a $8.35 copay for all other drugs

Other benefits and additional services

Physical exam

In-network: You pay nothing
Out-of-network: You pay 50%
In addition to the annual wellness visit you are eligible for an annual physical exam once every calendar year.

Chiropractic care

In-network: You pay a $20 copay
Out-of-network: You pay 50%
Limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).

Case management

Navigating the health care system can be a challenge, but when you're working through a health crisis, not knowing what to do can make things even harder. An advisor from Regence Case Management can help. If you face a serious medical situation, you'll have easy access to one-on-one support at no extra cost. Our staff, including registered nurses and clinical behavioral health specialists, is available to help you make sense of your health coverage and get the care you need.

Disease management

If you're living with a chronic condition, our disease management program can give you the tools and information you need to take an active role in your health.

This program helps you understand how to manage your condition day to day, supports your doctor's plan of care, and helps you improve your quality of life. It also gives you checklists and information to help you figure out how you are doing and general information about your condition. You can get answers about your condition and its treatment over the phone from a registered nurse disease manager. Our nurses use guidelines based on research evidence to decide what education and support might work best for you.

Personalized care support (palliative care)

Get one-on-one support if you or your loved one is facing a serious or life-limiting condition with our Personalized Care Support program. This program uses a team-based approach to coordinate care between medical providers and community resources so that you get the support you need when you need it most.

Wellness programs

These wellness programs are offered at no cost to you:

— The Silver&Fit® Exercise and Healthy Aging Program includes access to fitness facilities and fitness kits to use at home.
— Regence Advice24 is a 24-hour nurse line staffed by nurses who can help when you are in need of urgent health care advice.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a registered trademark of ASH and used with permission herein.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

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

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

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

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

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

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

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

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

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ 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)

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For more information, please call us at the phone number below or visit us at **regence.com/medicare**.

Prospective members call
1-888-319-8904 (TTY: 711)

Current members call
1-888-319-8904 (TTY: 711)

Hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday (from October 1 through February 14, our telephone hours are from 8:00 a.m. to 8:00 p.m., seven days a week).

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

REG-181580-17/09-17-OR