Premera Blue Cross Medicare Advantage Classic (HMO) offered by Premera Blue Cross

Annual Notice of Changes for 2024

You are currently enrolled as a member of Premera Blue Cross Medicare Advantage Classic (HMO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **premera.com/ma**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2023, you will stay in Premera Blue Cross Medicare Advantage Classic (HMO).
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with Premera Blue Cross Medicare Advantage Classic (HMO).
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 888-850-8526 for additional information. (TTY users should call 711.) Hours are:

  October 1 - March 31, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), seven days a week.

  April 1 - September 30, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), Monday through Friday. This call is free.
- This information is available in different formats, including braille and large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About Premera Blue Cross Medicare Advantage Classic (HMO)

- Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on contract renewal.
- When this document says "we," "us," or "our," it means Premera Blue Cross. When it says "plan" or "our plan," it means Premera Blue Cross Medicare Advantage Classic (HMO).

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Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Premera Blue Cross Medicare Advantage Classic (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$54	$54
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$5,000	$5,000
Doctor office visits	Primary care visits: $0 per in-person visit. $0 per virtual visit. Specialist visits: $30 per in-person visit. $25 per virtual visit.	Primary care visits: $0 per in-person visit. $0 per virtual visit. Specialist visits: $30 per in-person visit. $25 per virtual visit.
Inpatient hospital stays	For Medicare-covered hospital stays: $350 copay per day for days 1 through 4. $0 copay per day for days 5 through 90.	For Medicare-covered hospital stays: $350 copay per day for days 1 through 4. $0 copay per day for days 5 through 90.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 Preferred Generic: $2 • Drug Tier 2 Generic: $10 • Drug Tier 3 Preferred Brand: $40 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4 Non-Preferred Drug: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5 Specialty: 33% You pay $35 per month supply of each covered insulin product on this tier.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 Preferred Generic: $2 • Drug Tier 2 Generic: $10 • Drug Tier 3 Preferred Brand: $40 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4 Non-Preferred Drug: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5 Specialty: 33% You pay $35 per month supply of each covered insulin product on this tier.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 6 Select Care Drugs: Not covered. Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• Drug Tier 6 Select Care Drugs: $0 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$54	$54

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,000	$5,000 Once you have paid $5,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at **premera.com/ma**. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2024 *Provider and Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Ambulance services	You pay a $330 copay for Medicare-covered ambulance services (Air and Ground each way).	You pay a $275 copay for Medicare-covered ambulance services (Air and Ground each way).
Dental services	You pay a $75 annual deductible for routine comprehensive dental services.	You pay a $25 annual deductible for routine comprehensive dental services.
Health fitness program	The fitness/gym benefit includes free monthly membership at contracted gyms, orientation to the facility, and classes. Additionally, you can request to receive a home fitness kit from our contracted vendor.	The fitness/gym benefit includes 36 monthly credits at no cost to you for use on gym memberships and fitness studio classes in network, at-home fitness accessories and equipment, and unlimited access to premium digital

Cost	2023 (this year)	2024 (next year)
Health fitness program (continued)		wellness and fitness content. Number of credits may vary by fitness experience, for example: 1 class at your local yoga studio might cost 8 credits or 1 monthly membership at your local gym with unlimited visits might cost 24 credits. Digital wellness and fitness content is included at no additional charge in credits.
Medicare Part B prescription drugs	You pay a $35 copay per month supply of each Medicare-covered insulin product. You pay 20% of the total cost for Part B chemotherapy and other Medicare Part B drugs.	You pay a $35 copay per month supply of each Medicare-covered insulin product. You pay 0%-20% of the total cost for Part B chemotherapy and other Medicare Part B drugs.
Outpatient Ambulatory Surgical Center services	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $150 copay for each Medicare-covered ambulatory surgical center visit.
Over-the-Counter (OTC) items	You will receive a $50 credit per quarter for approved OTC items.	You will receive a $65 credit per quarter for approved OTC items.
Physician/practitioner services, including doctor's office visits	Referral is required for in-network specialists.	Referral is **not** required for **most** in-network specialists. See your *Evidence of Coverage* or call Customer Service for more details.

Cost	2023 (this year)	2024 (next year)
Vision care	We will not cover routine vision eyewear provided by: • Providers who opted out of Medicare • Providers not located in the United States or its territories.	We will not cover routine vision eyewear provided by: • Providers not located in the United States or its territories.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier**.

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells

you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** You pay $2 per prescription. **Tier 2 Generic:** You pay $10 per prescription. **Tier 3 Preferred Brand:** You pay $40 per prescription. You pay $35 per month supply of each covered insulin product on this tier.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** You pay $2 per prescription. **Tier 2 Generic:** You pay $10 per prescription. **Tier 3 Preferred Brand:** You pay $40 per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4 Non-Preferred Drug:** You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 Select Care Drugs:** Not covered. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	**Tier 4 Non-Preferred Drug:** You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 Select Care Drugs:** You pay $0 per prescription for 100-day supply. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Over-the-Counter (OTC) items	To find your nearest in-store location, go to **cvs.com/otchs/premera/storelocator**. OTC items orders may be placed via phone (1-888-628-2770) or online at **cvs.com/otchs/premera**.	To find your nearest location, go to **https://www.cvs.com/benefits**. OTC item orders may be placed via phone (1-888-628-2770) or online at **https://www.cvs.com/benefits**.
Member Correspondence return address	Member Correspondence PO Box 262548 Plano, TX 75026	Member Correspondence PO Box 211151 Eagan, MN 55121
Appeals and Grievances Department return address	Appeals and Grievances Department PO Box 262527 Plano, TX 75026	Appeals and Grievances Department PO Box 21481 Eagan, MN 55121

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Premera Blue Cross Medicare Advantage Classic (HMO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Premera Blue Cross Medicare Advantage Classic (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,

- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (**www.medicare.gov/plan-compare**), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, Premera Blue Cross offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Premera Blue Cross Medicare Advantage Classic (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Premera Blue Cross Medicare Advantage Classic (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription

drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Statewide Health Insurance Benefits Advisors (SHIBA) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Statewide Health Insurance Benefits Advisors (SHIBA) at 800-562-6900 (TTY 360-586-0241). You can learn more about Statewide Health Insurance Benefits Advisors (SHIBA) by visiting their website (**www.insurance.wa.gov/shiba**).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- "**Extra Help**" **from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Washington state has a program called Washington Prescription Drug Program (WPDP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Washington State ADAP known as the Early Intervention Program (EIP). The EIP provides services to

help eligible persons with HIV get the medications and assistance with insurance premium payments they need to improve and maintain their health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 877-376-9316.

SECTION 7 Questions?

Section 7.1 – Getting Help from Premera Blue Cross Medicare Advantage Classic (HMO)

Questions? We're here to help. Please call Customer Service at 888-850-8526. (TTY only, call 711.) We are available for phone calls

October 1 - March 31, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), seven days a week.

April 1 - September 30, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), Monday through Friday. Calls to these numbers are free.

Read your 2024 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Premera Blue Cross Medicare Advantage Classic (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **premera.com/ma**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **premera.com/ma**. As a reminder, our website has the most up-to-date information about our provider network *(Provider Directory)* and our *List of Covered Drugs (Formulary/"Drug List")*.

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) or 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.

Notice of availability and nondiscrimination 888-850-8526 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ຕ່ຣະ ການບໍລິການ ຕ່ຣະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມຕ່ຣະບບບໍ່ເສຍຄ່າ.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

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