PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS

Plan Selection Form

To be used by current Premera members only.

Please contact us at 888-868-7767 (TTY/TDD: 711) if you need help with your enrollment. Monday–Friday, 8 a.m. to 8 p.m. (or 7 days a week, 8 a.m. to 8 p.m., October 1–March 31).

PREMERA BLUE CROSS

PO Box 262548
Plano, TX 75026
Fax: 800-381-4837

YOUR INFORMATION

Name:	**Member number:**	
Home phone number:	Medicare number:	
Email address:		
Permanent residence (PO box is not allowed)		
Street address:		
City:	State:	Zip:
Mailing address (only if different from your permanent address)		
Street address:		
City:	State:	Zip:
Name of chosen Primary Care Provider (PCP):		
PCP location:		

please continue to the next page –

OFFICE USE ONLY

OFFICE USE ONLY:			
AGENT NAME:		WRITING #:	
SCOPE OF APPOINTMENT: ☐ PAPER ☐ APP MAILED TO AGENT ☐ SEMINAR (DATE / LOCATION):		AGENT RECEIVED DATE: EFFECTIVE DATE: SEP TYPE:	
PBP:	PLAN #:	CONTRACT #:	GROUP #:

OFFICE USE ONLY

CHOOSE YOUR MEDICARE ADVANTAGE PLAN

I am currently a member of the _____ plan in Premera Blue Cross Medicare Advantage, and my current monthly premium is $_____.

I want to transfer from my current Premera Blue Cross Medicare Advantage plan to the Premera Blue Cross Medicare Advantage plan I have selected below. I agree to allow Premera Blue Cross to use my personal information on file from my current Premera Blue Cross plan to complete my enrollment request.

I understand that this plan may have a different provider network and that I must pay the monthly premium (if any) in addition to any Medicare Part A and Part B premiums I may owe. **I understand that this plan has different health benefits and a monthly premium of $_____.** If this form is received by the end of the month, my new plan will generally be effective the 1st of the following month.

KING • PIERCE • SNOHOMISH • THURSTON

- ☐ **HMO - $0**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**
- ☐ **Classic Plus HMO - $191**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)

LEWIS • KITSAP • COWLITZ

- ☐ **HMO - $0**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**

SPOKANE

- ☐ **HMO - $0**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Total Health HMO - $24**

STEVENS

- ☐ **Total Health HMO - $24**

SKAGIT • ISLAND • SAN JUAN • WALLA WALLA

- ☐ **Core HMO - $12**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Core Plus HMO - $75**

WHATCOM

- ☐ **Core HMO - $12**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)
- ☐ **Classic (HMO) - $55**

please continue to the next page —

PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), 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 either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Premera Blue Cross the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the 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 local Social Security office, or call Social Security at 800-772-1213. TTY/TDD users should call 800-325-0778. You can also apply for extra help online at 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. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account Holder Name: Account type: ☐ Checking ☐ Savings

Bank Routing #: Bank Account #:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB)benefit check.

Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. Before the deduction begins, you may receive invoices for your premium. You will be responsible for paying your monthly premium directly to Premera from your effective date until the date your withholding begins. Invoices will stop once the deduction is approved. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.

I get monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board

Please check the box if you would prefer us to send you information in a language other than English or in another format: ☐ Spanish ☐ Braille

Please contact Premera Blue Cross at 888-850-8526 (TTY/TDD: 711) if you need information in another format or language than what is listed above. Our office hours are seven days a week, between 8 a.m. and 8 p.m.

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STOP — READ THIS IMPORTANT INFORMATION

PLEASE READ AND SIGN BELOW

Premera Blue Cross is a Medicare Advantage plan that has a contract with the Federal government.

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

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 Premera Blue Cross 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. 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my Premera Blue Cross Medicare Advantage coverage begins, I must get all of my health care from Premera Blue Cross, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Premera Blue Cross and other services contained in my Premera Blue Cross Medicare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS WILL PAY FOR THE SERVICES.**

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 from Medicare.

Signature: Today's date:

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

Name:

Address:

Phone: Relationship to enrollee:

Once you have completed this form, please mail it to this address:

Premera Blue Cross Medicare Advantage Plans
PO Box 262548, Plano, TX 75026
or fax it to 800-390-9656

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera depends on contract renewal.

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera 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: Civil Rights Coordinator — Complaints and Appeals, Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals, PO Box 262527, Plano, TX 75026, Phone: 888-850-8526, Fax: 800-889-1076, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. 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. 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 Ave 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-850-8526 (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 888-850-8526（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-850-8526 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-850-8526 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-850-8526 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-850-8526 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 888-850-8526 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 888-850-8526 (TTY: 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。888-850-8526（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 888-850-8526 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 888-850-8526 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-850-8526 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-850-8526 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-850-8526 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 888-850-8526 (TTY: 711).

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on renewal.