PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS

Plan Selection Form

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

For current Premera members only, please complete this form only if you wish to change plans. You can do this during the Annual Enrollment Period (October 15 and December 7) each year, for coverage starting January 1.

If you need help with your enrollment, please contact us at 888-868-7767 (TTY: 711) April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. October 1 - March 31, 7 days per week, 8 a.m. to 8 p.m.

PO Box 211151
Eagan, MN 55121
Fax: 800-381-4837

YOUR INFORMATION

Name:	**Member number:**	
Email address:	Medicare number:	
Phone:	Cell phone:	
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 primary care provider (PCP):		
PCP location:		

To file a complaint about your Medicare health or drug plan call 1-888-868-7767 (TTY: 711), or complete the Medicare Complaint form at **medicare.gov/my/medicare-complaint**. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. 1-800-MEDICARE is available 24 hours a day, 7 days a week, except some federal holidays. If applicable, please provide your agent or broker's name used for enrollment.

AGENT USE ONLY

REQUIRED FOR AGENT SUBMITTED APPLICATION		
AGENT NAME:		WRITING #:
Initial method of contact: Lead source:		
ENROLLMENT TYPE:		AGENT RECEIVED DATE:
☐ IN PERSON	☐ VIA EMAIL	EFFECTIVE DATE:
☐ TELEPHONIC	☐ MAILED TO AGENT	SEP TYPE:

AGENT USE ONLY

please continue to the next page –

CHOOSE YOUR MEDICARE ADVANTAGE PLAN

Current members can use this form to change health plans during the Annual Enrollment Period (October 15 and December 7). I am a current 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 December 7, my new plan will be effective January 1.

COWLITZ • ISLAND • KING • KITSAP • LEWIS • PIERCE • SAN JUAN • SKAGIT • SNOHOMISH • THURSTON • WHATCOM

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $54**

SPOKANE • WALLA WALLA

- ☐ **HMO - $0**
- ☐ **Total Health (HMO) - $23**
- ☐ **Classic (HMO) - $54** (not available in Spokane)

STEVENS

- ☐ **Total Health (HMO) - $23**

please continue to the next page –

RACE (OPTIONAL)

- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Guamanian or Chamorro
- [ ] Japanese
- [ ] Korean
- [ ] Native Hawaiian
- [ ] Another Asian origin
- [ ] Another Pacific Islander origin
- [ ] Samoan
- [ ] Vietnamese
- [ ] America Indian or Alaska Native
- [ ] Black or African American
- [ ] White
- [ ] I choose not to answer

ETHNICITY (OPTIONAL)

- [ ] Not of Hispanic, Latino/a/x, or Spanish origin
- [ ] Puerto Rican
- [ ] Another Hispanic, Latino/a/x, or Spanish origin
- [ ] Mexican, Mexican American, Chicano/a/x
- [ ] Cuban
- [ ] I choose not to answer

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 costs. 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 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.

You will automatically receive a monthly bill for your plan premium, if any, including any late enrollment penalty that you may have incurred. Or you can choose a different payment option listed below:

☐ 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 a paper bill for your monthly premiums.

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

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

If you need information in another format or language than what is listed above, please contact Premera Blue Cross at 888-850-8526 (TTY: 711) April 1 - September 30, Monday to Friday, 8 a.m. to 8 p.m. (or October 1 - March 31, 7 days per week, 8 a.m. to 8 p.m.).

please continue to the next page –

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, they 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 healthcare 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 healthcare 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 a 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 211151
Eagan, MN 55121
or fax it to 800-381-4387

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

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Notice of Nondiscrimination

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, sex, gender identity, or sexual orientation. 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
  - Written information in other formats (large print, audio, 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, 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, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator — Complaints and Appeals
Premera Blue Cross Medicare Advantage Plans
PO Box 21481, Eagan, MN 55121
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.

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Enrollment in Premera Blue Cross depends on contract renewal.

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Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-850-8526 (TTY/TDD: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-850-8526 (TTY/TDD: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-850-8526 (TTY/TDD: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-850-8526 (TTY/TDD: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-850-8526 (TTY/TDD: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-850-8526 (TTY/TDD: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-850-8526 (TTY/TDD: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-850-8526 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-850-8526 (TTY/TDD: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-850-8526 (TTY/TDD: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-850-8526 (TTY/TDD: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-850-8526 (TTY/TDD: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-850-8526 (TTY/TDD: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-850-8526 (TTY/TDD: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-850-8526 (TTY/TDD: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-850-8526 (TTY/TDD: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-850-8526 (TTY/TDD: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。