

2024 Premera Medicare
Advantage (HMO)

Enrollment Kit

MEDICARE + YOU

PREMERA | 

BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

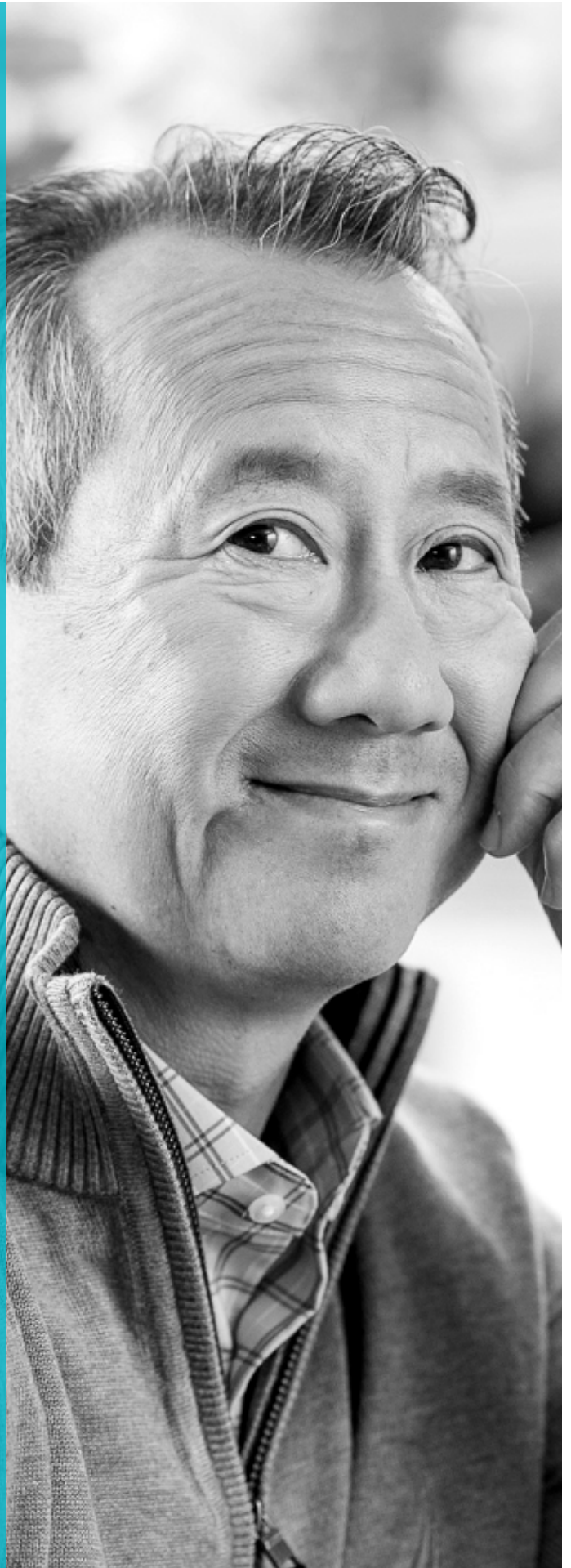


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Introduction

Let us help you simplify Medicare

Welcome to Premera Blue Cross! We believe an informed choice is the best choice, especially when it comes to your healthcare. Within this enrollment kit, you will find everything you need to compare our plans and find the one that best fits your life.

Please review each piece carefully. If you have questions while going through the kit, please use the resources below:

- Reach out to your producer
- View the **Online Resources** document on page 5
- Visit **PremeraMedicare.com**
- Contact us at **888-868-7767** (TTY: 711) 8 a.m. – 8 p.m., seven days a week from October 1 through March 31; or 8 a.m. – 8 p.m., Monday through Friday from April 1 to September 30.



Enrollment instructions

Once you are ready to enroll in a Premera Medicare Advantage Plan, you have a few options.

1 **Connect with your Medicare producer**

Contact your producer using the contact information found on the cover of this kit to let them know you are ready to submit a Premera Blue Cross Medicare Advantage enrollment application.

2 **Enroll online**

Choose “Shop Plans” on **PremeraMedicare.com** to submit an enrollment application or continue comparing plans.

3 **Call us at 888-868-7767 (TTY: 711)**

Customer Service representatives are ready to assist you in this paperless enrollment process. Our hours of operation are:

October 1 – March 31: 8 a.m. – 8 p.m., 7 days a week

April 1 – September 30: 8 a.m. – 8 p.m., Monday – Friday

4 **Print, fill out, and mail the form on pages 10 through 15 to:**

Premera Blue Cross

PO Box 211151

Eagan, MN 55121

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

Online resources

The Premera Blue Cross Medicare Advantage (HMO) website contains many resources to help you use your plan. Please see below for commonly requested items available for free on our website, premera.com/ma.

Find a provider, dentist, or hospital	To find a medical or dental provider in your area, visit premera.com/ma and click on Find Care .
Find a pharmacy	To find a pharmacy in your area, visit premera.com/ma and click on Find a pharmacy .
Formulary (list of covered drugs)	To see what drugs are covered, visit premera.com/ma and click on Find a drug .
Evidence of Coverage	To view a copy of the Evidence of Coverage for your plan, visit premera.com/ma . Select the Coverage & Benefits tab, then choose your plan.
Secure member portal	When your Premera Medicare Advantage membership begins, activate your online member account. Here, you can find useful information about your membership, including the ability to review claims or reorder an ID card if needed. Just click Sign In in the upper right-hand corner of premera.com/ma .

To receive a paper copy of the above materials, or request materials in a language other than English, call customer service, **888-850-8526 (TTY: 711)** 8 a.m. – 8 p.m., seven days a week from October 1 through March 31; or 8 a.m. – 8 p.m., Monday through Friday from April 1 to September 30.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a customer service representative at **888-850-8526** (TTY: 711) 8 a.m. to 8 p.m., seven days per week from October 1 through March 31; or 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30.

The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit premera.com/ma or call **888-850-8526** to view a copy of the EOC.

Understanding the benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a provider.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctor you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review our formulary (list of covered drugs) to see if your current prescription drugs are covered.
- ☐ To view a copy of plan-specific EOCs, a complete list of all prescription drugs covered by Premera Blue Cross Medicare Advantage, or access our full provider and pharmacy directories, visit us online at premera.com/ma or call **888-850-8526** (TTY: 711) 8 a.m. to 8 p.m., seven days per week from October 1 through March 31; or 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30.

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

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Understanding important rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments and coinsurance may change on January 1, 2024.
- ☐ **Effect on current coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must meet the following requirements:

- Be a U.S. citizen or be lawfully present in the United States
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (hospital insurance)
- Medicare Part B (medical insurance)

When do I use this form?

You can join a plan during the following times:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during the Annual Enrollment Period (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Premera Blue Cross
PO Box 211151
Eagan, MN 55121

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Premera Blue Cross Medicare Advantage at 888-868-7767 (TTY: 711). Or, call Medicare at 1-800-MEDICARE (800-633-4227). TTY users can call 1-877-486-2048.

Llame a Premera Blue Cross Medicare Advantage al 888-868-7767 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, one of the following may be considered your permanent residence:

- A post office box
- An address of a shelter or clinic
- An address where you receive other mail (such as social security checks)

Important: Do not send this form or any items with your personal information (such as claims, payments, medical records, and more) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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](https://www.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.

Section 1 – All fields on this page are required

(unless marked optional)

All plans include preventive and comprehensive dental.

SELECT THE PLAN YOU WANT:

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

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

SPOKANE • WALLA WALLA

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

STEVENS

- ☐ **Total Health (HMO) - \$23**

YOUR INFORMATION

First name:	Last name:	Mid initial:
Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Phone:
Email address:	Cell phone:	
Permanent residence (PO Box is not allowed)		
Street address:	City:	
County (optional):	State:	ZIP code:
Mailing address , only if different from permanent residence address (PO Box allowed)		
Street address:	City:	
State:	Zip:	
Emergency contact		
Name:	Phone:	
Relationship to you:		
Name of primary care provider (PCP):		
PCP location:		

PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please use your Medicare card to complete this section.

- Fill in the blanks so they match your red, white, and blue Medicare card.

OR

- Attach a copy of your Medicare card, your letter from Social Security, or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):

Medicare #:

Is entitled to	Effective Date
HOSPITAL (Part A)	
MEDICAL (Part B)	

REQUIRED FOR AGENT SUBMITTED APPLICATION

AGENT USE ONLY

AGENT USE ONLY

AGENT NAME:		WRITING #:
Initial method of contact:		
Lead Source:		
ENROLLMENT TYPE:	AGENT RECEIVED DATE:	
<input type="checkbox"/> IN PERSON	<input type="checkbox"/> VIA EMAIL	EFFECTIVE DATE:
<input type="checkbox"/> TELEPHONIC	<input type="checkbox"/> MAILED TO AGENT	SEP TYPE:

READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription coverage in addition to Premera Blue Cross? ☐ Yes ☐ No

If "yes," list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Premera Blue Cross.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Premera Blue Cross will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan, unless it is an MA PFFS or an MA MSA plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Premera Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Premera Medicare Advantage. Benefits and services provided by Premera Medicare Advantage and contained in my Premera Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Premera Medicare Advantage will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under state law to complete this enrollment.
 - 2) Documentation of this authority is available upon request by Medicare.

Signature: _____ Date: ____ ____ ____

If you're the authorized representative, sign above and fill out these fields:

Name: _____ Phone: _____

Address: _____

Relationship to enrollee: _____

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select a check box if you want us to send you information in a language other than English. ☐ Spanish

Select a check box if you want us to send you information in an accessible format. ☐ Braille ☐ Large print

☐ Other: _____

Contact Premiera Medicare Advantage at 888-868-7767 (TTY: 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. – 8 p.m., seven days a week from October 1 through March 31; or 8 a.m. – 8 p.m., Monday through Friday from April 1 to September 30.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

RACE AND ETHNICITY

RACE

- | | |
|--|--|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Pacific Islander origin |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> America Indian or Alaska Native |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Korean | <input type="checkbox"/> White |
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Other Asian origin | |

ETHNICITY

- ☐ Not of Hispanic or LatinX, or Spanish origin
- ☐ Puerto Rican
- ☐ Another Hispanic or LatinX, or Spanish origin
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ I choose not to answer

Paying your plan premiums

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 having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **Don't** pay Premera Blue Cross the Part D-IRMAA.

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. Enclose a **voided** check or provide the following:

Account holder name:	Account: <input type="checkbox"/> Checking <input type="checkbox"/> 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

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), to improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50, and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on contract renewal. Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolling during the Annual Enrollment Period from October 15 through December 7.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _____.
- ☐ I recently returned from incarceration. I was released on _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____.
- ☐ I recently obtained lawful presence status in the United States. I got status on _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____.
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums, or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on _____.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example: a nursing home or long-term care facility). I moved, plan to move in, or plan to move out of the facility on _____.
- ☐ I recently left a PACE program on _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's coverage). I lost my drug coverage on _____.
- ☐ I am leaving employer or union coverage on _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, OR Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on _____.
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Premiera Blue Cross at 888-868-7767 (TTY: 711) to see if you are eligible to enroll. Our office hours are 8 a.m.—8 p.m., seven days a week from October 1 through March 31; or 8 a.m.—8 p.m., Monday through Friday from April 1 to September 30.

MEDICARE ADVANTAGE (HMO)



2024 Benefit Highlights



BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

You deserve peace of mind about your Medicare Advantage plan coverage.



Our plans include an array of great benefits to help build the healthiest you, from head to toe:

- \$0* monthly premiums available
- Low out-of-pocket maximum
- No referrals needed for in-network specialists
- Preventive and comprehensive dental: \$1000 - \$1500
- Excellent hearing aid benefit: Bluetooth and rechargeable batteries - 3 levels of hearing aids at \$0 added cost
- Physical therapy copays as low as \$10 per session*
- \$0* drug deductibles available
- Tier 6 adherence drugs: \$0 copay for 100-day supply (retail or mail order)
- 60-day readmission hospital benefit, regardless of reason for readmission (one per benefit period)
- Predictable cost for outpatient surgery, diagnostic testing, radiology, and hospital observation
- Ambulance copay includes ground and air
- Whole-body benefits, including routine vision care; eyewear allowance, naturopathic and chiropractic care; acupuncture; and much more*
- Over-the-counter allowance
- Gym membership and fitness kit

Access to your trusted providers

- Choose from over 25,000 providers.
- Access care from any provider or hospital in our Medicare network with a referral from your primary care provider (PCP).
- Visit **premera.com/ma** and select **Find care** to find your provider.

*Not available on all plans and not all plans are available in all counties

2024 Plan highlights

Your health is everything and we've got you covered. With service in 14 counties, we're confident we can provide you with a plan to fit your needs.

Total Health

Spokane, Stevens, and Walla Walla Counties

Premium	\$23
Annual out-of-pocket maximum	\$5,000
Primary care provider (PCP) / Specialist	\$0 / \$30
Outpatient ambulatory surgical center	\$150
Outpatient hospital observation	\$90
Inpatient hospital	\$350 per day (days 1-4) \$0 per day (days 5-90+)

HMO

Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom Counties

Premium	\$0
Annual out-of-pocket maximum	\$6,500
Primary care provider (PCP) / Specialist	\$5 / \$40
Outpatient ambulatory surgical center	\$150
Outpatient hospital observation	\$90
Inpatient hospital	\$450 per day (days 1-4) \$0 per day (days 5-90+)

Classic

Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom Counties

Premium	\$54
Annual out-of-pocket maximum	\$5,000
Primary care provider (PCP) / Specialist	\$0 / \$30
Outpatient ambulatory surgical center	\$150
Outpatient hospital observation	\$90
Inpatient hospital	\$350 per day (days 1-4) \$0 per day (days 5-90+)

Enroll today!



IN PERSON:

Contact your producer or local territory manager



BY MAIL:

Return your paper application to:

**Premera Blue Cross
Medicare Advantage Plans
PO Box 211151
Eagan, MN 55121**



ONLINE:

Go to **premera.com/ma**

Questions?

You can contact us at **888-868-7767 (TTY: 711)** from 8 a.m. to 8 p.m., seven days per week from October 1 through March 31; or from 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30.

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

On behalf of Premera Blue Cross, Hearing Care Solutions, OTC Health Solutions, and FitOn Health are independent companies that provide the hearing aid program, the over-the-counter allowance program, and the fitness program benefit respectively.

To join a Premera Blue Cross Medicare Advantage Plan, you must have Medicare Part A and Part B and live in the Premera Blue Cross Medicare Advantage service area.

Members must select a PCP from the Premera Blue Cross Medicare Advantage Plans provider network.

2024 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO)

PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO)

2024 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001

PREMERA BLUE CROSS MEDICARE ADVANTAGE CLASSIC (HMO) H7245-002

PREMERA BLUE CROSS MEDICARE ADVANTAGE TOTAL HEALTH (HMO) H7245-005

Counties covered:

Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Cowlitz	Cowlitz	Spokane
Island	Island	Stevens
King	King	Walla Walla
Kitsap	Kitsap	
Lewis	Lewis	
Pierce	Pierce	
San Juan	San Juan	
Skagit	Skagit	
Snohomish	Snohomish	
Spokane	Thurston	
Thurston	Walla Walla	
Walla Walla	Whatcom	
Whatcom		

This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO) and Premera Blue Cross Medicare Advantage Total Health (HMO) from January 1, 2024 to December 31, 2024.

Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO) and Premera Blue Cross Medicare Advantage Total Health (HMO) are plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

The benefit information provided 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” by calling customer service or accessing it on our website: premera.com/ma.

To join **Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO) or Premera Blue Cross Medicare Advantage Total Health (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Washington: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, and Whatcom.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

This document is available in other formats, including Braille and Spanish.

For more information, please call us at 888-850-8526 (TTY/TDD: 711), or visit us at premera.com/ma.

Representatives are available:

October 1 – March 31, 8 a.m. to 8 p.m., (Pacific Time), 7 days a week

April 1 – September 30, 8 a.m. to 8 p.m., (Pacific Time), Monday through Friday

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Monthly Plan Premium You must continue to pay your Medicare Part B premium	\$0	\$54	\$23
Part C Deductible This plan does not have a deductible	\$0	\$0	\$0
Part D Deductible	\$0 for Tier 1, Tier 2 and Tier 6 \$160 for Tier 3, Tier 4 and Tier 5	\$0	\$0
Maximum Out-of-Pocket Responsibility Includes copays and other costs for medical services for the year. Does not include prescription drugs.	\$6,500	\$5,000	\$5,000
Inpatient Hospital Coverage* A benefit period begins the day you go into the hospital and ends when you have not received any inpatient hospital care for 60 days in a row. You pay nothing if readmitted within 60 days of receiving inpatient hospital care.	\$450 copay per day: days 1-4 \$0 copay per day: days 5 and beyond	\$350 copay per day: days 1-4 \$0 copay per day: days 5 and beyond	\$350 copay per day: days 1-4 \$0 copay per day: days 5 and beyond
Outpatient Hospital Coverage*	\$350 copay	\$300 copay	\$275 copay
Outpatient Hospital Observation Coverage*	\$90 copay	\$90 copay	\$90 copay
Ambulatory Surgery Center*	\$150 per visit	\$150 per visit	\$150 per visit

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Doctor Visits			
Primary care providers	\$5 copay \$0 copay per telehealth visit	\$0 copay \$0 copay per telehealth visit	\$0 copay \$0 copay per telehealth visit
Specialists PCP Referral may be required for out-of-network specialist services.	\$40 copay \$35 copay per telehealth visit	\$30 copay \$25 copay per telehealth visit	\$30 copay \$25 copay per telehealth visit
Preventive Care Such as flu vaccine and diabetic screening. For a full list of covered preventive services, see your plan's Evidence of Coverage.	\$0 copay	\$0 copay	\$0 copay
Emergency Care Includes worldwide coverage. If you are admitted to the hospital within 24 hours, the Emergency Care copay is waived.	\$90 copay	\$90 copay	\$90 copay
Urgently Needed Services If you are admitted to the hospital within 24 hours, the Urgently Needed Services copay is waived.	\$35 copay \$50 copay for worldwide coverage	\$35 copay \$50 copay for worldwide coverage	\$35 copay \$50 copay for worldwide coverage

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Diagnostic Services/Labs/Imaging			
Diagnostic tests and procedures* (per service location, per day)	\$60 copay	\$30 copay	\$30 copay
Lab services*	\$10 copay	\$0 copay	\$0 copay
Outpatient X-rays	\$15 copay	\$10 copay	\$10 copay
Therapeutic radiology services (such as radiation treatment for cancer)* If your doctor provides additional services, a separate cost-sharing amount may apply.	20% coinsurance	20% coinsurance	20% coinsurance
Diagnostic radiology services* (such as MRI, CT scan)	\$180 copay	\$160 copay	\$160 copay
Hearing Services			
Medicare-covered hearing exam	\$35 copay	\$30 copay	\$30 copay
Routine hearing exam (1 per calendar year)	\$35 copay	\$30 copay	\$30 copay
Hearing Care Solutions provider; higher copay applies to exams by all other providers.	\$0 copay	\$0 copay	\$0 copay
Hearing aids when purchased through Hearing Care Solutions	\$0 copay \$1,000 annual allowance per ear	\$0 copay \$1,000 annual allowance per ear	\$0 copay \$1,000 annual allowance per ear

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Dental Services			
Medicare-covered comprehensive dental services	\$45 copay	\$30 copay	\$30 copay
Annual maximum allowance for non-Medicare covered preventive and comprehensive dental services	\$1,000	\$1,500	\$1,500
Annual Comprehensive Dental Deductible (in-network and out-of-network)	\$25 deductible. No deductible for preventive and Medicare-covered dental services.		
Preventive dental services	\$0 copay for exams, fluoride, cleanings, and X-rays. Refer to your Evidence of Coverage (EOC) for limitations.		
Comprehensive dental services	\$0 copay for covered comprehensive dental services, like fillings, extractions, crowns, and dentures. Refer to your Evidence of Coverage (EOC) for limitations.		

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Vision Services			
Medicare-covered vision exam Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year**	\$0 copay	\$0 copay	\$0 copay
Medicare-covered exam to diagnose and treat diseases and conditions of the eye	\$20 copay	\$30 copay	\$30 copay
Medicare-covered vision hardware	\$0 copay	\$0 copay	\$0 copay
Routine vision exam (1 per calendar year)	\$20 copay	\$0 copay	\$0 copay
Routine vision hardware for lenses and frames or contacts per calendar year	\$150 allowance	\$250 allowance	\$200 allowance

^ PCP referral may be required.

* Prior authorization is required.

** Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Mental Health Services			
<p>Inpatient mental health care*</p> <p>A benefit period begins the day you go into the hospital and ends when you have not received any inpatient hospital care for 60 days in a row.</p> <p>You pay nothing if readmitted within 60 days of receiving inpatient mental health care.</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>	<p>\$390 copay per day: days 1-4</p> <p>\$0 copay per day: days 5-90</p>
Outpatient mental health care	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>	<p>\$30 copay per visit</p> <p>\$20 copay per telehealth visit</p>
Skilled Nursing Facility*	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>	<p>\$0 copay per day: days 1-20</p> <p>\$160 copay per day: days 21-60</p> <p>\$0 copay per day: days 61-100</p>
Physical Therapy	\$20 copay	\$10 copay	\$10 copay
<p>Ambulance*</p> <p>Prior authorization required only for non-emergencies.</p> <p>(per one-way trip)</p>	<p>\$300 copay for ground</p> <p>\$300 copay for air</p>	<p>\$275 copay for ground</p> <p>\$275 copay for air</p>	<p>\$275 copay for ground</p> <p>\$275 copay for air</p>

^ PCP referral may be required.

* Prior authorization is required.

Premium and Benefits	Medicare Advantage (HMO)	Medicare Advantage Classic (HMO)	Medicare Advantage Total Health (HMO)
Transportation	Not covered	Not covered	Not covered
Medicare Part B Drugs*	0%–20% coinsurance	0%–20% coinsurance	0%–20% coinsurance
Medicare Part B Insulin Drugs*	\$35 copay	\$35 copay	\$35 copay
Over-the-Counter (OTC) Credit per quarter. Purchase products including At-Home COVID-19 tests available through OTC Health Solutions.	\$50	\$65	\$65
Chiropractic Services (Medicare-covered)	\$15 copay	\$20 copay	\$20 copay
Routine Chiropractic Services	\$20 copay, 6 visits per year	\$20 copay, 10 visits per year	\$20 copay, 10 visits per year
Acupuncture* (Medicare-covered)	\$40 copay	\$30 copay	\$30 copay
Routine Acupuncture	\$20 copay, 6 visits per year	\$20 copay, 10 visits per year	\$20 copay, 10 visits per year
Routine Naturopathic Services	Not covered	\$30 copay, 6 visits per year	\$30 copay, 6 visits per year
Fitness Program Monthly credits available for use on gym memberships, fitness studio classes, at-home fitness accessories and equipment and unlimited access to premium digital wellness content.	\$0 copay	\$0 copay	\$0 copay

^ PCP referral may be required.

* Prior authorization is required.

Important Message About What You Pay for Vaccines

Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's Drug List or contact Member Services for coverage and cost-sharing details about specific vaccines.

Important Message About What You Pay for Insulin

You won't pay more than \$35 for a one-month (up to 30-day) supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

If you qualify for "Extra Help", you could benefit from reduced cost sharing for the insulins covered under Part D. Please refer to your plan's drug list to find a comprehensive list of Part D insulins covered by your plan.

Prescription Drug Benefits (Part D):

Deductible Phase

Medicare Advantage (HMO)

No deductible for Tier 1, Tier 2, and Tier 6. This plan has a **\$160** deductible for Tier 3, Tier 4, and Tier 5 drugs. You pay the full cost of these drugs, except for Part D covered insulins as noted above, until you reach **\$160**. Then, you only pay your cost-share.

Medicare Advantage Classic (HMO) and Medicare Advantage Total Health (HMO)

No deductible.

Initial Coverage Phase (after you pay your deductible, if applicable)

You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach **\$5,030**. Total yearly drug costs are the total drug costs paid by both you and your plan. Once you reach this amount, you will enter the Coverage Gap.

Coverage Gap

After you enter the coverage gap, you pay **25%** coinsurance of the plan's cost for covered brand name drugs and **25%** of the plan's cost for covered generic drugs until your out-of-pocket costs total **\$8,000** — 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 your 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 **\$8,000**, your cost for covered drugs will be \$0.

	Medicare Advantage (HMO)		Medicare Advantage Classic (HMO)		Medicare Advantage Total Health (HMO)	
	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)	Retail Cost Sharing (up to 30-day supply)	Mail Order Cost Sharing (90-day supply)
Tier 1: Preferred Generic	\$4 copay (30-day supply)	\$0 copay (90-day supply)	\$2 copay (30-day supply)	\$0 copay (90-day supply)	\$2 copay (30-day supply)	\$0 copay (90-day supply)
Tier 2: Generic	\$12 copay (30-day supply)	\$36 copay (90-day supply)	\$10 copay (30-day supply)	\$30 copay (90-day supply)	\$10 copay (30-day supply)	\$30 copay (90-day supply)
Tier 3: Preferred Brand	\$42 copay (30-day supply)	\$126 copay (90-day supply)	\$40 copay (30-day supply)	\$120 copay (90-day supply)	\$40 copay (30-day supply)	\$120 copay (90-day supply)
Tier 4: Non-Preferred Drugs	\$100 copay (30-day supply)	\$300 copay	\$100 copay (30-day supply)	\$300 copay (90-day supply)	\$100 copay (30-day supply)	\$300 copay (90-day supply)
Tier 5: Specialty	30% coinsurance	Not offered	33% coinsurance	Not offered	33% coinsurance	Not offered
Tier 6: Select Care Drugs	\$0 copay (100-day supply)	\$0 copay (100-day supply)	\$0 copay (100-day supply)	\$0 copay (100-day supply)	\$0 copay (100-day supply)	\$0 copay (100-day supply)
	Cost sharing may change when you enter another of the four phases of the Part D benefit.		Cost sharing may change when you enter another of the four phases of the Part D benefit.		Cost sharing may change when you enter another of the four phases of the Part D benefit.	

You pay the copays and coinsurance in the chart shown above until your total yearly drug costs reach **\$5,030**.

When you get a 31- to 90-day supply of drugs in Tiers 1-4, the copays listed above in the chart will be multiplied as follows:

- If you get a 31- to 60 day supply from one of our retail pharmacies, (retail or mail order), you pay twice the copay amount.
- If you get a 61- to 90-day supply from one of our retail pharmacies, you pay three times the copay amount.

Premera Blue Cross
Monthly Plan Premium for People who get Extra Help from Medicare
to Help Pay for their Prescription Drug Costs

If you get extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get extra help from Medicare.

If you get extra help, your monthly plan premium will be \$0 for any of the plan(s) below. (This does not include any Medicare Part B premium you may have to pay.)

- Premera Blue Cross Medicare Advantage (HMO)
- Premera Blue Cross Medicare Advantage Total Health (HMO)

The Premera Blue Cross Medicare Advantage Classic (HMO) plan premium will be \$22.90 for members who qualify for the subsidy.

Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), and Premera Blue Cross Medicare Advantage (HMO)'s premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting extra help, you can see if you qualify by calling:

- 1-800-Medicare or TTY users call 1-877-486-2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778 between 7 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please call Premera Blue Cross Customer Service at 888-850-8526, (TTY/TDD users should call 711) from 8 a.m. to 8 p.m. PST seven days a week from October 1 through March 31; 8 a.m. to 8 p.m. PST, Monday through Friday from April 1 through September 30.

IMPORTANT INFORMATION:

2024 Medicare Star Ratings

Premera Blue Cross Medicare Advantage - H7245

Official U.S.
Government
Medicare
Information



For 2024, Premera Blue Cross Medicare Advantage - H7245 received the following Star Ratings from Medicare:

Overall Star Rating: ★★☆☆☆

Health Services Rating: ★★☆☆☆

Drug Services Rating: ★★☆☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars shows how well our plan performs.

★★★★★	Excellent
★★★★☆	Above average
★★★☆☆	Average
★★☆☆☆	Below average
★☆☆☆☆	Poor

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Premera Blue Cross Medicare Advantage October 1 through March 31, 7 days a week, 8:00 a.m. to 8:00 p.m. Pacific time at 888-868-7767 (toll-free) or 711 (TTY) April 1 through September 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. Pacific time. Current members please call 888-850-8526 (toll-free) or 711.



Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

(Refer to the following page for product type descriptions.)

- | | |
|---|---|
| <input type="checkbox"/> Stand-alone Medicare Prescription Drug Plans | <input type="checkbox"/> Medicare Advantage Plans |
| <input type="checkbox"/> Dental/Vision/Hearing Products | <input type="checkbox"/> Critical Illness and Accident Products |
| <input type="checkbox"/> Medicare Supplement (Medigap) Products | |

By signing the form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. **Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment status, or enroll you in a Medicare plan. Scope of Appointment documentation is subject to CMS record retention requirements.**

Beneficiary or Authorized Representative Signature and Signature Date		
Signature:	Signature Date:	Signature Time:
If you are the Authorized Representative, please sign above and print below:		
Representative's Name:	Your Relationship to the Beneficiary:	
Representative's Address:	Representative's Phone:	
To be completed by Agent:		
Agent Name:	Agent Phone:	
Beneficiary Name:	Beneficiary Phone:	
Beneficiary Address:		
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)		
Lead Source:		
Agent's Signature:		
Plan(s) the agent represented during the meeting:	Date Appointment Completed:	
Plan Use Only:		
Agent, if the form was signed by the beneficiary at time of appointment provide explanation why SOA was not documented prior to meeting:		

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO) – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Point of Service (HMO-POS) Plan – A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Medicare Special Needs Plan (SNP) – A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Dental/Vision/Hearing Products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.
Critical Illness and Accident Products
Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products
Plans offering a supplemental policy to fill “gaps” in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Scope of Appointment documentation is subject to CMS record retention requirements. Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on contract renewal.

Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

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>.

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

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 quý vị cần thông dịch viên xin gọi 1-888-850-8526 (TTY/TDD: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelpfen. 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 대해 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.

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