PREMERA BLUE CROSS

Group Medicare Supplement Plan G Washington Health Care Authority

Dear Washington State Resident:

Thank you for your interest in Medicare Supplement Plan G.

Please find enclosed	• Outline of Medicare Supplement Coverage • Group Medicare Supplement Enrollment Application/Eligibility Attachment (see *State Residents)* • Automatic Funds Transfer Agreement (authorization for automatic payment program) • Notice to Applicant regarding replacement of Medicare Supplement Coverage • Release of information authorization form (only necessary of you would like to authorize another person to have access to your information)
What's next?	Submit your completed application/eligibility attachment and any other information via • Fax to: 425-918-5278 • Mail to: PO Box 327, MS 295 Seattle, WA 98111

If you have any questions or need help with enrollment, please call us at 888-208-6264. Our toll-free TDD number for the hearing impaired is 800-842-5357.

Sincerely,

Premera Blue Cross

052932 (12-22-2020)
P202088 (01-01-2022)

Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage

PO Box 327, MS 295
Seattle, WA 98111

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APPLICANT LAST NAME FIRST NAME SUBSCRIBER ID NUMBER

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract to be issued by Premera Blue Cross. Your new contract will provide (30) days within which you may decide, without cost, whether you desire to keep the contract.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this contract.

STATEMENT TO THE APPLICANT

We have reviewed your currrent medical or health insurance coverage. To the best of our knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.

The replacement contract is being purchased for the following reason(s) (please check one):

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D

☐ Disenrollment from a Medicare Advantage plan.
Please explain reason for disenrollment: _____

☐ Other (please specify): _____

State law provides that your replacement contract or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods in the new contract to the extent such time was spent (depleted) under original policy.

AFTER THE APPLICATION HAS BEEN COMPLETED AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.

Do not cancel your present policy until you have received your new contract and are sure that you want to keep it.

APPLICANT'S SIGNATURE	DATE

Send original to Premera Blue Cross, PO Box 327, MS 295 Seattle, WA 98111

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA | BLUE CROSS

See Outlines of Coverage sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Only applicants' before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K[2]	L[2]	M	N[3]	C	F[1]
Medicare Part A coinsurance and Hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit					$6,620	$3,310				

[1]Plan F and G also have a high deductible option which require first paying a plan deductible of $2,490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Washington State Health Care Authority

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2022)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $99.35	Plan G $193.70	Plan G $188.70	Plan G $377.40

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $165.39	Plan G $325.78	Plan G $320.79	Plan G $641.58

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The Group policy is the insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to PO Box 327, MS 295, Seattle, Washington 98111. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do *NOT* cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

G PLAN G: MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the plan's Basic Benefits. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

G **PLAN G (continued):**

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $233 of Medicare approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	3 pints	$0
Next $233 of Medicare approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0
MEDICARE (PARTS A & B)			
HOME HEALTH CARE - Medicare approved services			
Medically Necessary Skilled Care Services and Medical Supplies	100%	$0	$0
Durable Medical Equipment			
First $233 of Medicare approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PREMERA BLUE CROSS

P.O. Box 327, MS 295
Seattle, WA 98111-9220

Group Medicare Supplement Enrollment Application Washington State Health Care Authority

You can become a Washington State Health Care Authority Medicare Supplement member if you:

- Are eligible for the group's Medicare supplement plan
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

For Office Use Only
Group Number: _____
Effective Date of Coverage: _____
Enrollee Class (if applicable): _____

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted. PLEASE RETURN ALL THE PAGES OF THE APPLICATION EVEN IF THEY ARE BLANK.

A Your Information

Applicant

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Last Name	First Name	Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)		City	County	State	ZIP
Mailing Address (if different from above)		City	County	State	ZIP
Daytime Phone Number		Email Address			
Birthdate *Month*	*Day*	*Year*	Gender ☐ Male ☐ Female		

Dependent

I am eligible for Medicare Part A and B because: ☐ Age 65+ ☐ Under Age 65
I have Medicare due to: ☐ Kidney Dialysis or Kidney Transplant

Relationship to Applicant: _____

Last Name	First Name	Middle Initial	Social Security Number (required)		
Home Address (cannot be a P.O. Box)		City	County	State	ZIP
Mailing Address (if different from above)		City	County	State	ZIP
Daytime Phone Number		Email Address			
Birthdate *Month*	*Day*	*Year*	Gender ☐ Male ☐ Female		

B What Plan Do You Want?

Which Medicare supplement plan do you want to enroll in? ☒ Plan G

Did you receive a copy of the Premera Blue Cross "Outline of Coverage"? ☐ Yes ☐ No

Did you receive a copy of Medicare's "Choosing A Medigap Policy" guide? ☐ Yes ☐ No

C Your Other Health Coverage

Please answer all the questions below as best you know how.

Applicant

Tell Us About Your Medicare Coverage (You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ☐No

b. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

Your Medicare Information Here

MEDICARE HEALTH INSURANCE

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

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	____ / 01 / _____
Part B Medical Insurance	____ / 01 / _____

Tell Us About Your Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐Yes ☐No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)

If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare

Supplement plan? (You can't keep both.) ☐Yes ☐No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave 3.b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program?
Note To Applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Dependent

Tell Us About Your Medicare Coverage
(You have to have Medicare Parts A and B to Enroll)

1. a. Did you turn age 65 in the last 6 months? ☐Yes ☐No

b. Did you enroll in Medicare Part B in the last 6 months? ☐Yes ☐No

c. If **Yes**, what is the effective date? (month and year) _____ / 01 / _____

(See your Medicare card to find this date.)

Dependent's Medicare Information Here

Please fill in your Medicare number and effective dates in the box to the right. You can copy from your Medicare card. Or, it's OK to include a copy of your Medicare card instead. We need these numbers to enroll you.

MEDICARE HEALTH INSURANCE

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

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ - ____ - _____ - ____

IS ENTITLED TO	**EFFECTIVE DATE**
Part A Hospital Insurance	____ / 01 / _____
Part B Medical Insurance	____ / 01 / _____

Tell Us About Your Dependent's Medicare Advantage Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 2.a., b., c. and d.

2. a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐Yes ☐No

If Yes, fill in your **start** and **end** dates below. (OK to put in just the month and year.)
If you are still covered under this plan, leave "End" blank.

Start: _____ / _____ / _____ End: _____ / _____ / _____

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan? (You can't keep both.) ☐Yes ☐No

c. Was this your first time in this type of Medicare plan? ☐Yes ☐No

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐Yes ☐No

Tell Us About Your Dependent's Medicare Supplement Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 3.a. and c. Leave b. blank.

3. a. Do you have another Medicare Supplement policy in force? (These plans are called Plan A, B, C, D, F, G, K, L, M or N) ☐Yes ☐No

b. If Yes, with what company, and what plan do you have? (If you know, put the insurance company name and the plan name (such as Plan F) in the blanks.)

Company: _____ Plan: _____

c. If Yes, do you intend to replace your current Medicare Supplement policy with this plan? (You can't keep both.) ☐Yes ☐No

Tell Us About Any Other Dependent Individual Or Group Health Insurance Coverage, If Any

If you didn't have this kind of coverage, just check "No" to 4.a., and leave b. and c. blank.

4. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan). ☐Yes ☐No

b. If Yes, with what company and what kind of policy? (If you know, put in the insurance company name and the type of policy, such as group coverage through your spouse or individual coverage.)

Company: _____ Policy: _____

c. What are your dates of coverage under the other policy? **If you are still covered under the same policy**, leave "End" blank. (It's OK to put just the month and year or just the year.)

Start: _____ / _____ / _____ End: _____ / _____ / _____

Tell Us About Any Help With Your Dependent's Medical Bills You Receive From Your State's Medicaid Programs

This doesn't mean Social Security benefits or food stamps. It can include payment for nursing home care. If you didn't have this kind of help from State Medicaid, just check "No" to 5.a., b. and c.

5. a. Are you covered for any medical assistance through the state Medicaid program?
Note To Applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer **No** to this question. ☐Yes ☐No

b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan? ☐Yes ☐No

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐Yes ☐No

Proceed to section D

D Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true.

1. I am an eligible member of the group.
2. I have **both** Medicare Parts A and B in force today.
3. I understand that my coverage does not start until Premera accepts this application and assigns an effective date.
4. I authorize Premera, at its option, to pay doctors and other providers directly for health care I receive.
5. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
6. I also understand and agree that Premera may cancel this coverage back to its start date as if I never had coverage at all, if it is found that I have supplied false information, or any information was omitted by me or for me, on this application, and that information is material enough to affect my eligibility for coverage. (Please note: After coverage has been in force for two years, coverage may no longer be canceled for this reason.)
7. I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions. Examples are to determine my eligibility for enrollment or to pay claims. If Premera discloses my personal information for any other reason, Premera will first take out any data that can be used to easily identify me, or will get my signed permission.

Be sure to sign and date this application, include all pages of the application and provide any proof required for "yes" answers in section C, when submitting to Premera for processing.

Signature of Applicant	Today's Date
X	

Signature of Dependent	Today's Date
X	

Please Note: If you have a Medicare supplement or Medicare Advantage policy today (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete the "Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Coverage" form.

If you have any questions, please contact your benefit department or Premera at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a “Qualified Medicare Beneficiary” (QMB) or a “Specified Low-Income Medicare Beneficiary” (SLMB).
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days of losing your employer or union based group health plan.

Who Is Eligible For Coverage?

Public Employees Benefit Board (PEBB) Program Retirees, Survivors, or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible retiree, survivor, or PEBB continuation coverage (COBRA) subscriber and enroll during one of the periods listed below:

- Upon initial enrollment in PEBB insurance coverage.
- Within six months of initial enrollment in Medicare Part B.
- If you deferred PEBB retiree health plan coverage, you may enroll during any PEBB Program annual open enrollment or no later than 60 days after the date other qualified coverage ends.
- Existing PEBB subscribers may change their coverage by applying for another plan during a PEBB Program annual open enrollment or a special open enrollment period, established by the PEBB Program.
- During other enrollment periods, if any, established by the PEBB Program.

Dependents of PEBB Program Retirees or PEBB Continuation Coverage (COBRA) Subscribers

To be eligible, you must be an eligible spouse or state-registered domestic partner and enroll during one of the periods listed below:

- At the same time as the PEBB retiree or PEBB Continuation Coverage (COBRA) subscriber.
- Within six months of initial enrollment in Medicare Part B.
- During a PEBB Program annual open enrollment or a special open enrollment period established by the PEBB Program.

State Residents

To be eligible, you must be a current Washington State resident and enroll during one of the periods listed below:

- No earlier than 30 days before you become eligible for Part A and Part B of Medicare.
- Within six months of initial enrollment in Medicare Part B provided that you are replacing a health plan with no lapse in coverage of more than 63 days.
- Within six months of attaining age 65 or older and is enrolled in Medicare Part B.
- Within 63 days of establishing Washington State residency. Residency date: _____
- Within 63 days of losing coverage under a retiree group health plan, a Medicare Advantage plan, a health care prepayment plan, a Program of All-Inclusive Care for the Elderly, a Medicare supplement or Medicare SELECT plan, or a Medicare risk or cost plan for reasons that qualify under federal law. Your answers in section C of the application will determine if you qualify.
- When replacing coverage or enrolling during a guaranteed issue period, as allowed by law. Your answers in section C of the application will determine if you qualify.

Customer Agreement Automatic Funds Transfer Authorization Monthly Payment Program

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

PO Box 91120, MS 295
Seattle, WA 98111-9220

Subscriber or applicant name (please print)		Subscriber ID #		
Home address (not PO Box) Street	City:	State:	Zip:	County:

Mailing address (only if different from your permanent address) street address:

City	State	Zip	County
Telephone number - home	Telephone number - mobile		

AUTOMATIC FUNDS TRANSFER AUTHORIZATION

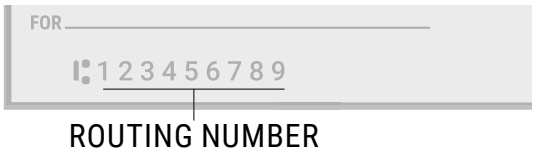
I have selected the monthly AFT payment option and I hereby authorize Premera Blue Cross to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name

Account Holder's Name (print)

City	State	Zip	Account number	
Bank Routing Number*			☐ Checking	☐ Savings

*9-digit number at bottom of check (for checking account) or deposit slip (for savings account)



You may also attach a voided check or deposit slip to confirm accuracy of banking information.

ADDITIONAL TERMS AND CONDITIONS

- Funds are to be transferred on the fifth day of each month, or as soon thereafter as practical, to pay for that month's coverage (for example: The December fifth deduction pays for coverage in December).
- If the automatic withdrawal date falls on a weekend or holiday, your deduction will be taken on the next business day.
- I understand that this Automatic Funds Transfer Authorization (AFT) will remain in effect until Premera Blue Cross has received notice from me that it should be cancelled. To ensure prompt cancellation of my AFT, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date.
- It may take as long as 45 days to set up an AFT. You may receive an invoice to pay the initial payment.

Signature:	Today's date:

Before mailing:

- **Review** banking information written above
- **Attach** a deposit slip or voided check (optional)
- **Check** to make sure your bank accepts automatic withdrawals
- **Keep** a copy of all items submitted for your files.

Mail completed Automatic Funds Transfer Authorization form to: PO BOX 91120, MS 295, SEATTLE, WA 98111

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

Information Release Form

Follow the steps to authorize Premera Blue Cross (Premera) to release your protected health information.

1 Member's Information:

First Name:	
Last Name:	
Date of Birth: MM/DD/YY	☐☐/☐☐/☐☐
ID #:	☐☐☐☐☐☐☐☐☐☐ Suffix ☐☐

2 Who are you authorizing?

First Name:	Last Name:	Phone:	
Relationship to member: ☐ Check here if this person is on the same plan as you.		Fax:	
Address:	City:	State:	Zip Code:

3 Why are you authorizing them?

Must check at least one:

- ☐ At my own request
- ☐ At Premera's request for: ☐ Research ☐ Other: _____
- ☐ Other (state specific date, specific time period, event or condition):_____

4 Review and Sign:

Premera Blue Cross, or any of its affiliates (the "Company"), may disclose my health records, claims, billing, and eligibility information with the Authorized Representative listed above. I understand that the healthcare information may include my benefit, claim, diagnosis and treatment records including information about the following sensitive healthcare diagnosis that I have checked in the boxes below.

What types of information should we share with the person in Section 2? Check all that apply: Must check at least one

- ☐ General Health Information
- ☐ Alcohol and/or Chemical Dependency
- ☐ Sexually Transmitted Diseases (HIV/AIDS)
- ☐ Genetic Information
- ☐ Reproductive Health (including abortion)
- ☐ Gender affirming care, gender dysphoria, domestic violence, and behavioral health

Can they see your online accounts? Access will not be granted unless you check "yes" below.

Premera.com Online Account Profile: Authorized individual must be an enrolled parent, spouse, or domestic partner on the plan.

☐ **Yes,** allow the authorized individual to view all claims, including sensitive claims, and online account profile (benefit summary including usage, limits, spending, activity report, etc.)

Personal Funding Account with ConnectYourCare: ☐ **Yes,** I authorize to have all claims, including sensitive claims available within the subscriber's Personal Funding Account.

You can change your mind and withdraw this release at any time by informing the Company in writing at the address listed at the bottom of this form. The Company will make sure the change goes into effect within five business days after receiving your withdrawal request and will not be liable for any information released before your change goes into effect. The person or entity that receives the member's information may be able to share it. State and federal privacy rules may no longer protect it. This release is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this release. This release will last twenty-four months from the signature date below, or until you cancel it. This request applies only to your current health plan.

Signature (print form to sign): X	**Date of Signature:**
Printed Name:	

5 If not the member, I am the:

☐ Legal Guardian* ☐ Parent* ☐ Holder of Power of Attorney/Legal Representative (must attach supporting legal documentation)

**The legal guardian or parent may sign for the member only if member is age 12 or younger, or member is age 13 to 17 and only releasing general health information in section 4.*

Mail to: Member Appeals PO Box 91102 Seattle, WA 98111 **Fax:** 425-918-5592

PREMERA | BLUE CROSS

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state 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 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, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, 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. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (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 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (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。800-722-1471（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 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.