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

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)*** ○ Note: each applicant for State Resident coverage will need to complete their own application • Notice to Applicant regarding replacement of Medicare Supplement Coverage • Automatic Funds Transfer Agreement (authorization for automatic payment program) • 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: Fax to: 425-918-5278 Mail to: Premera Blue Cross PO Box 327, MS 295 Seattle, WA 98111

If you have any questions or need help with enrollment, please call us at 800-722-1471 (TTY: 711).

Sincerely,

Premera Blue Cross

052932 (09-01-2024)

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA BLUE CROSS

See Outlines of Coverage sections for details 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					$7,060	$3,530				

[1]Plan F and G also have a high deductible option which requires first paying a plan deductible of $2,800 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, 2025)

Eligible By Reason of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $114.80	Plan G $223.89	Plan G $218.18	Plan G $436.36

Eligible By Reason of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G $193.60	Plan G $381.49	Plan G $370.89	Plan G $741.78

Please Note: The subscription 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 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 your payments will be returned.

CERTIFICATE REPLACEMENT

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

NOTICE

This certificate may not fully cover all 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 all questions truthfully and completely. 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 $1,632	$1,632 (Part A Deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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

Group Medicare Supplement Enrollment Application Washington State Health Care Authority – WA State Residents

PO Box 327, MS 295
Seattle, WA 98111-9220
800-722-1471
Fax: 425-918-5278

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

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 type your answers or print clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Personal 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	Suffix	First Name	Middle Initial

Home Address (cannot be a PO Box or business address)	City	County	State	Zip
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip

Phone Number	Alternate Phone Number

Email Address*	Birthdate (Month/Day/Year)	Gender
		☐ Male ☐ Female

*Important Note (state resident only): *We can send enrollment notifications, information about how to use your plan, and a copy of this application to you by email instead of a paper copy.*
Do you want to receive enrollment notifications, information about how to use your plan, and a copy of this application to you by email?

☐ Yes ☐ No

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ America Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Two or more races
☐ Other race

Ethnicity (Optional)

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If your proficient in the English language, as well as others, please select English from the list. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

☐ Arabic	☐ Chinese	☐ English	☐ French/Haitian Creole French
☐ German	☐ Greek	☐ Italian	☐ Japanese
☐ Korean	☐ Polish	☐ Portuguese	☐ Russian
☐ Spanish	☐ Tagalog	☐ Vietnamese	☐ Other: _____

ATTENTION:
Only answer this next section if applying for PEBB retiree coverage.
Don't fill out this dependent section if you are applying for Washington state resident coverage.

Dependent (PEBB retiree only)

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	Suffix	First Name	Middle Initial

Home Address (cannot be a PO Box or business address)	City	County	State	Zip
Mailing Address (if different from above)	City	County	State	Zip
Billing Address (if different from both above)	City	County	State	Zip

Phone Number	Alternate Phone Number

Email Address	Birthdate (Month/Day/Year)	Gender
		☐ Male ☐ Female

Race (Optional)

Premera is committed to serving the diverse needs of all our members. These fields are completely optional. If you'd like to self-identify, please do so. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

- ☐ America Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Two or more races
- ☐ Other race

Ethnicity (Optional)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If your proficient in the English language, as well as others, please select English from the list. The collection of this information will not determine eligibility, rating, or claim payments.

(Check one)

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French/Haitian Creole French
- ☐ German
- ☐ Greek
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____

B Plan Selection

Which Medicare Supplement plan do you want to enroll in?

☐ Plan G

All covered family members must enroll in the same plan.

C Medicare Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions:**

Applicant
To the best of your knowledge:

☐ Y ☐ N 1. Did you turn 65 in the last 6 months?

☐ Y ☐ N 2. Will you turn 65 in the next 6 months?

☐ Y ☐ N 3. Did you enroll in Medicare Part B in the last 6 months?

Medicare Number (11 alphanumeric characters as seen in the image above)	
Hospital (Part A) Effective Date	Medicare (Part B) Effective Date

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

Dependent

To the best of your knowledge:

☐ Y ☐ N 1. Did you turn 65 in the last 6 months?

☐ Y ☐ N 2. Will you turn 65 in the next 6 months?

☐ Y ☐ N 3. Did you enroll in Medicare Part B in the last 6 months?

Medicare Number (11 alphanumeric characters as seen in the image above)	
Hospital (Part A) Effective Date	Medicare (Part B) Effective Date

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

D Other Healthcare Information

Please review the statements below, then answer all questions to the best of your knowledge.

- You do not need more than one Medicare Supplement insurance policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension.
- 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 benefit 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. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Applicant

1. Tell us about any help you receive from your state's Medicaid program (required):

☐ Y ☐ N 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.

☐ Y ☐ N b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☐ N c. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____

2. Tell us about your Medicare Supplement coverage (required):

☐ Y ☐ N a. Do you have another Medicare Supplement policy in force? If so, with what company, and what plan do you have?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

☐ Y ☐ N b. If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

☐ Y ☐ N a. If you've 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), fill in your start and end dates below. If you are still covered under this plan, leave end date blank.

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

☐ Y ☐ N b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?

☐ Y ☐ N c. Was this your first time in this type of Medicare plan?

☐ Y ☐ N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

☐ Y ☐ N a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

ATTENTION:
Only answer this next section if applying for PEBB retiree coverage.
Don't fill out this dependent section if you are applying for Washington state resident coverage.

Dependent

1. Tell us about any help you receive from your state's Medicaid program (required):

☐ Y ☐ N 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.

☐ Y ☐ N b. If yes, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☐ N c. Have you recently lost coverage for medical assistance through the state Medicaid program?

If yes, when did it end? _____

2. Tell us about your Medicare Supplement coverage (required):

☐ Y ☐ N a. Do you have another Medicare Supplement policy in force? If so, with what company, and what plan do you have?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

☐ Y ☐ N b. If so, do you intend to replace your current Medicare Supplement policy with this plan?

3. Tell us about your Medicare Advantage coverage (required):

☐ Y ☐ N

a. If you've 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), fill in your start and end dates below. If you are still covered under this plan, leave end date blank.

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number: _____

☐ Y ☐ N

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

☐ Y ☐ N

c. Was this your first time in this type of Medicare plan?

☐ Y ☐ N

d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

4. Tell us about any other group or individual health insurance coverage (required):

☐ Y ☐ N

a. Have you had coverage under any other health insurance within the past 63 days? For example, an employer, union, or individual plan.

If so, with what company, and what kind of policy?

Company & plan type: _____

Member ID: _____

Start date: _____ End date: _____

Customer Service Phone Number:

_____

E Authorization and Verification of Information

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. I understand coverage is available to me due to: (1) my residing in Washington. (2) my enrollment in Medicare Parts A and B, (3) my eligibility for Medicare due to age (65 or over), and (4) I don't receive Medicaid assistance other than payment of my Medicare Part B premium. I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

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, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I further understand that any physician, healthcare provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

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.

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 2 or 3 in Section D, you must complete and sign the attached replacement notice.

☐ I acknowledge receipt of the Guide to Health Insurance for People with Medicare and the Outline of Coverage.

I have read all the information and have answered all questions to the best of my ability.

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Signature of applicant X	Today's date

Signature of dependent X	Today's date

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: Be sure to return the entire application!

Continue to the next page for the Replacement Notice

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

Group Medicare Supplement Eligibility Attachment
Washington State Health Care Authority
Public Employees Benefits Board (PEBB) Program

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.

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

PO Box 327, MS 295
Seattle, WA 98111

PREMERA | BLUE CROSS

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

Customer Agreement Automatic Funds Transfer Authorization Monthly Payment Program

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

PO Box 327, 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

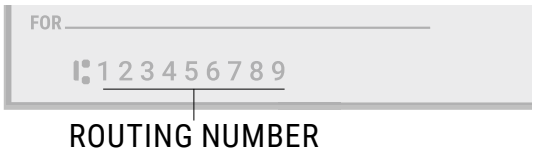
I have selected the monthly AFT payment option and I hereby authorize Premera Blue Cross to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

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)



ROUTING NUMBER

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 327, 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. Questions? Please call the customer service number on the back of your member ID card.

1 Member Information:

First Name:

Last Name:

Date of Birth: MM/DD/YY

ID #: Suffix

2 Whom 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: ☐ **Yes,** I authorize to have all claims, including sensitive claims available within the subscriber's Personal Funding Account (only applicable if the subscriber's Personal Funding Account is administered by Premera).

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

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک ها و خدمات امدادی متناسب تماس بگیرید.

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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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