Premera Medicare Supplement

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:

- Visit **premera.com/MS**
- **Call us at 800-752-6663** (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 Supplement plan, you have a few options.

1 **Enroll online**

Visit **premera.com/MS** to enroll online. There, you can use our digital tool to submit an enrollment application or continue comparing plans.

2 **Call us at 800-752-6663 (TTY: 711)**

Premera Medicare representatives are ready to assist you in our paperless enrollment process. Our hours of operation are as follows:

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

3 **Connect with a local Premera Medicare specialist**

Our Medicare specialists will connect you with a local expert who can help you with your insurance needs. If you are not currently enrolled, visit **premera.com/Medicare** for more information.

4 **Print, fill out, and mail the form on pages 22 through 34 to the following address:**

Premera Blue Cross

PO Box 327, MS 295

Seattle, WA 98111

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

Outline of Medicare Supplement Coverage

By Reason of Age – Cover Page:
Benefit Plans A, C, G, High Deductible G and N

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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. Some plans may not be available in your state. Only applicants first eligible for Medicare before 2020 may purchase Plans **C**, **F,** and high deductible **F**.

Plans offered by Premera Blue Cross (Premera) are highlighted below.

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 require 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.

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

SUBSCRIPTION CHARGE INFORMATION

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

NEW SPOUSAL DISCOUNT

Starting June 1, 2024, you may be eligible for a discount on your premium if you qualify for our spousal discount. Eligibility requires both beneficiaries to be enrolled in a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later) and have the same address. You also must be married or a state-registered domestic partner. You can request the discount by visiting **ms.premera.com,** then select **Coverage and Benefits**. Download and complete the form and then send it back to us to apply for the discount. Mail the completed form to PO Box 327, MS 295, Seattle, Washington 98111, or fax it to 425-918-5278.

PAYMENT MODE OPTIONS

Monthly payment by Automatic Funds Transfer (AFT). Rates shown reflect a $5 monthly discount for AFT payments compared to the Paper Bill Option.

OR

If you prefer us to bill you, Premera will send you a paper bill in the mail each month.

Monthly Subscription Charges Per Person

	Standard Rate (Effective April 1, 2024)		With Spousal Discount (Effective June 1, 2024)	
Plan	**AFT**	**Paper Bill**	**AFT**	**Paper Bill**
Plan A	$180	$185	$162	$167
Plan C	$246	$251	$221	$226
Plan G	$215	$220	$193	$198
Plan G High Deductible	$53	$58	$47	$52
Plan N	$178	$183	$160	$165

DISCLOSURES

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

READ YOUR CONTRACT VERY CAREFULLY

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

RIGHT TO RETURN CONTRACT

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

POLICY REPLACEMENT

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

NOTICE

This contract 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

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

A PLAN A: 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 A PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A Deductible)
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	$0	Up to $204 a day
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 "Core 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.

A PLAN A (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 A 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	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$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)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
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

C PLAN C: 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 C 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 "Core 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.

C PLAN C (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 C 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	$240	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
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	$240 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

C PLAN C (continued): OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
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

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 "Core 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	All costs	$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)

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
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

G PLAN G (continued): OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
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

G HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would normally be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, 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 "Core 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 HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would normally be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, 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 (Unless Part B deductible has been met)
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	All costs	$0
Next $240 of Medicare approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

G HIGH DEDUCTIBLE PLAN G (continued): MEDICARE (PARTS A & B)

*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.

**This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would ordinarily be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, YOU PAY
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 (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, YOU PAY
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

PLAN N:
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 N 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 "Core 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.

N PLAN N (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 N 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%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the member is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the member is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$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

N PLAN N (continued): MEDICARE (PARTS A & B)

*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 N PAYS	YOU PAY
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

PLAN N (continued): OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
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

Washington Medicare Supplement Enrollment Application for Plans A, C, G, High Deductible G, and N

PO Box 327, MS 295
Seattle, WA 98111
800-752-6663
Fax: 425-918-5278

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

You are eligible to apply for a Premera Blue Cross (Premera) Medicare Supplement Plan if you:

- Reside in Washington (excluding Clark County),
- Currently have both Medicare Part A and Part B, and
- Don't receive Medicaid assistance other than payment of your Medicare Part B Premium
- 65 years of age or older

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

Last Name	Suffix	First Name	Middle Initial

Home Address (cannot be a PO Box or business address)	City	County	State WA	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: *We can send enrollment notifications, information about how to use your plan, your Welcome Kit, 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, your Welcome Kit, 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: _____

B Plan Selection

Which Medicare Supplement plan do you want to enroll in?

☐ Plan A ☐ Plan C ☐ Plan G ☐ Plan G High Deductible ☐ Plan N

Note: Only those applicants who are initially eligible for Medicare before January 1, 2020, may apply for Plan C.

Plan Start Date

You are eligible for coverage to start on the first of the month after the postmark date if all information is completed and accurate and we approve your application. Please indicate the month you want your coverage to start.

I want this plan to begin on the first of _____. (No more than 90 days after the application is signed.)
(enter month)

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:**

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.

If you answered YES to 1 or 2, please skip the Health Statements (Section F). The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

D Payment and Premium Discounts (optional)

DO NOT send payments with this application.

You will get monthly paper bills if you do not select automatic monthly withdrawals.

A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.

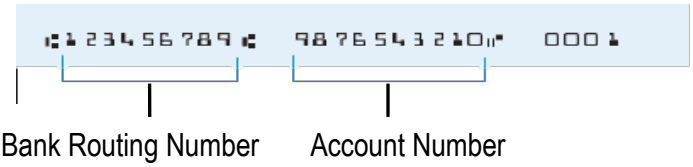
Tip – Save on your premiums Sign up for our automatic monthly withdrawals (AFT) or our spousal discount (if eligible) and you will save on your monthly premiums. Call us at 800-722-1471 for more information.

Please complete this section if you are selecting automatic monthly withdrawal

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account holder's name (print)			
Financial institution or bank name			
Bank routing number (see below)	Account number (see below)	☐ Checking	☐ Savings

Fill out the information above. To ensure accuracy of your automatic withdrawal, we recommend that you send us a photocopy of your voided check.



Additional terms and conditions:

- Funds are transferred on the fifth business day of each month to pay for that month's coverage. For example, the deduction on February 5th pays for coverage in February.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure cancellation, I must notify Premera no later than the twentieth of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Bank account holder signature X	Today's date

Please complete this section if you are applying for our spousal discount

You may be eligible for a discount on your premium if you qualify for our spousal discount. Eligibility requires both beneficiaries to be enrolled on a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later) and have the same address. Spouse is defined as married or as state-registered domestic partners.

Please check one:

☐ My spouse is currently covered under a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later).

Spouse's First Name	Spouse's Last Name
Spouse's Date of Birth	
Spouse's Premera ID Number (9-digit number)	

☐ My spouse is applying for a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later).

Spouse's First Name	Spouse's Last Name
Spouse's Date of Birth	
Spouse's Medicare Beneficiary Number (11 alphanumeric characters)	

Additional terms and conditions:

- Each applicant must complete a separate application and be approved.
- The spousal discount will continue as long as both members are enrolled.
- If we are unable to verify your eligibility, you will be enrolled, however, you will not receive the spousal discount.
- NOTE: The discount may not appear on your next invoice. It could take up to 60 days to reflect on your account. The discount will not be applied retroactively, it will go into effect on the day it is activated on your account.

E 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).

1. Tell us about any help you receive from your state's Medicare 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. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?

☐ Y ☐ N d. 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 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 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: _____

F Do I need to complete health questions?

When applying for Plan A, C, G, High Deductible G, or N, you do not need to complete Section G if any of the following is true.

1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area, and you apply for Medicare Supplement (Medigap) coverage after you receive notice that your coverage is terminating or ceasing, and no later than 63 days after your coverage terminates or ceases.
2. Your employer group health plan coverage that supplements the benefits under Medicare ends or ceases to provide all such supplemental benefits to you, and you apply for Medicare Supplement (Medigap) coverage after (a) your coverage is met or ceases, or (b) you receive notice that your coverage is terminating or ceasing, whichever is later, and no later than 63 days after your coverage terminates.
3. Your Medicare Supplement (Medigap) insurance company goes bankrupt, and you lose your coverage, or your Medicare Supplement (Medigap) policy coverage ends through no fault of your own, and you apply for Medicare Supplement (Medigap) coverage beginning on the earlier of your coverage terminating or you are receiving notice of termination or bankruptcy, and no later than 63 days after your coverage terminates.
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medicare Supplement (Medigap) policy that covers outpatient prescription medications, and you apply for Medicare Supplement (Medigap) coverage up to 60 days before the initial Medicare Part D enrollment period and no later than 63 days after the effective date of your Medicare Part D coverage. Please enclose proof of enrollment in Medicare Part D.
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare, and you apply for a Medicare Supplement (Medigap) coverage up to 60 days before and no later than 63 days after your Medicare Advantage or PACE program coverage terminates.
6. You dropped a Medicare Supplement (Medigap) policy to join a Medicare Advantage or PACE program for the first time and now you want to leave. You have been in the plan for no more than a year and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates. A health statement is not required if you enroll in the same Medicare Supplement (Medigap) policy (with the same company) that you had previously, if available.
7. You leave a Medicare Advantage plan or drop a Medicare Supplement (Medigap) plan because the company or its representatives haven't followed the rules or misled you, and you apply for a Medicare Supplement (Medigap) policy up to 60 days before and no later than 63 days after your plan terminates.
8. You currently are enrolled in a standardized Medicare Supplement (Medigap) plan issued in 1990 or later, and you wish to switch to a plan with either greater, equal, or lesser benefits. (For example, from a 1990 standard Plan F to a 2010 standard Plan F.) Exception: if you have Plan A, you can only switch to Plan A without requiring underwriting.

G Your Health Conditions

Answer these health questions to determine if you are eligible for this coverage.

If any statements in Section F apply to you, skip this section, and move on to Section H.
If no statements in Section F apply to you, fill out this section.

1. Do any of these conditions apply to you? ☐ Y ☐ N

- End stage renal (kidney) disease
- Currently receiving dialysis
- Diagnosed with kidney disease that may require dialysis
- Cirrhosis/liver failure
- Chronic obstructive pulmonary disorder (COPD)
- Have a bleeding (coagulation defect), blood disorder, or leukemia
- Rheumatoid arthritis, joint replacement
- Schizophrenia, bipolar mood, attempted suicide, or eating disorder
- Transplant (excludes corneal)
- Insulin dependent diabetes

2. Within the past 5 years, has a medical professional diagnosed, discussed, or recommended treatment options for any of the following conditions? ☐ Y ☐ N

- Alcohol, or chemical/drug abuse or dependence
- DVT (clots) or PVD (peripheral vascular disease)
- Stroke/TIA or paralysis
- Prostatitis
- Heart attack, congestive heart failure, coronary artery disease, pacemaker, stenosis, or heart valve prolapse or transplant
- Ulcerative colitis or Crohn's disease
- Chronic bronchitis or tuberculosis
- Chronic back/neck/disc problems

If you answered YES under questions 1 or 2 in this section, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to both questions 1 and 2, your answer to questions 3 and 4 will be used to determine if your application will be accepted.

3. Height and weight:

Height	Weight / lbs.
Feet Inches	

4. Have you taken medications within the past year?

☐ **Yes.** Please enter your medication information in the table provided below.

☐ **No.** Please move to Section H.

Medication Name	How long have you been taking this medication?	What does this medication treat?

H 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 (excluding Clark County). (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 that the Medicare Supplement contract will not pay benefits during the first three months after the effective date for any condition for which I have had treatment, medicine, or diagnostic testing within the three months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. **The waiting period may be waived if I apply for this contract within 63 days of leaving other healthcare coverage and I provide proof with this application.**

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 2 or 3 in Section E, 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.

Signature of applicant X	Today's date

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

! ! ! IMPORTANT: Be Sure to Return the Entire Application ! ! !

Continue to the next page for the Replacement Notice

For producer use only

Be sure to return this page to us even if you do not have a producer.

If this application is being submitted through a producer, they must complete the information below and the attached Notice of Replacement, if appropriate. If all questions are not answered completely, the application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. _____

   _____

2. List policies sold which are still in force. _____

   _____

3. List policies sold in the past five years which are no longer in force. _____

   _____

Producer name (please print)	Premera producer number (5 numeric digits)
Producer email address	Producer contact number
Producer signature X	Date

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

PO Box 327, MS 295
Seattle, WA 98111-0327

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

Applicant last name | First name | Subscriber ID number

Save this notice! It may be important to you in the future!

According to your application, 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 thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

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 applicant by issuer, producer, or other representative

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy 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 policy is being purchased for the following reason(s):

☐ Additional benefits
☐ No change in benefits, but lower premiums
☐ Disenrollment from a Medicare Advantage Plan.
Please explain reason for disenrollment: _____
☐ Other (please specify): _____
☐ Fewer benefits and lower premiums
☐ Plan has outpatient prescription drug coverage and you are enrolling in Part D

1. If you have had your current Medicare Supplement policy less than three months, health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement contract or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. Premera Blue Cross will waive any time periods applicable to 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.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force.

Do not cancel your present policy until you have received your new contract and are sure that you want to keep it. If you have any questions, please call us at 800-752-6663 or contact your producer.

Signature of producer or representative (signature not required for direct response sales) **X**	Printed name of producer or representative
Applicant's signature **X**	Date

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

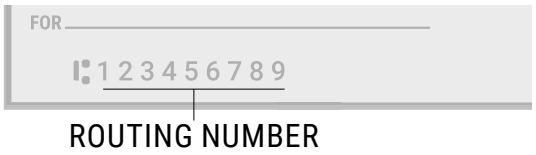
I have selected the monthly AFT payment option and I hereby authorize Premera Blue Cross to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

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)



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

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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر 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.