2017 Premera Medicare Advantage Plan Information

Thank you for your interest in applying for the Premera Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Premera within 7 days of the application receipt.

Enrollment Packet – click links below to view the information
Star Rating **Online application** Download Application Summary of Benefits Provider Search Formulary Multi-language Support

Initial Enrollment Period (IEP)
If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.
Annual Enrollment Period (AEP)
Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.
Special Enrollment Period (SEP)
There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC PO Box 26540 Eugene, Oregon 97402	Fax: 1.541.284.2994 or 888.632.5470 Secure File Upload: Click here Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://hiwa.us/

PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS

Enrollment Request Form

Please contact us **888-868-7767 (TTY:711)** if you need help with your enrollment.
Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., October 1–February 14)

PREMERA | BLUE CROSS

P.O. Box 4198
Portland, OR 97208-4198

ENROLL IN PREMERA BLUE CROSS (check the plan you want)

Plan with optional dental available:

☐ Premera Blue Cross Medicare Advantage (HMO) - $0
☐ Add Optional Dental Plan - $26

Plans with dental included:

☐ Premera Blue Cross Medicare Advantage Classic (HMO) - $75
☐ Premera Blue Cross Medicare Advantage Classic Plus (HMO) - $128

Last Name: First Name: Mid Int: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: / / Sex: ☐ M ☐ F Phone: ( )

Email Address:

Permanent residence (P.O. box is not allowed)

Street Address: City:

County: State: Zip:

Mailing address (only if different from permanent residence address)

Street Address: City:

County: State: Zip:

Emergency contact

Name: Phone: ( )

Relationship to You:

Choose the name of a Primary Care Provider (PCP):

PCP Location:

PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

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

OR

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

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

MEDICARE HEALTH INSURANCE
SAMPLE SAMPLE

NAME _____

MEDICARE CLAIM NUMBER **SEX**

___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___ _____

IS ENTITLED TO **EFFECTIVE DATE**
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

OFFICE USE ONLY

OFFICE USE ONLY:

AGENT NAME: Tiffany Jackson		WRITING #: 6376V0698
SCOPE OF APPOINTMENT: ☐ PAPER ☐ SEMINAR (DATE / LOCATION): ☐ T-SCOPE ☐ APP MAILED TO AGENT		AGENT RECEIVED DATE: EFFECTIVE DATE: SEP TYPE:
PBP:	TRAN. CODE:	PLAN #:
GROUP #:	CONTRACT #:	PREMIUMS:

OFFICE USE ONLY

PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Premera Blue Cross the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 800-772-1213. TTY users should call 800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. Enclose a VOIDED check or provide the following:

Account Holder Name: Account type: ☐ Checking ☐ Savings

Bank Routing #: Bank Account #:

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. Before the deduction begins, you may receive invoices for your premium. You will be responsible for paying your monthly premium directly to Premera from your effective date until the date your withholding begins. Invoices will stop once the deduction is approved. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

READ AND ANSWER THESE IMPORTANT QUESTIONS

1. **Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No**
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
2. Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other coverage in addition to Premera Blue Cross? ☐ Yes ☐ No
   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: _____
   ID # for this coverage: _____ Group # for this coverage: _____
3. **Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No**
   If "yes," please provide the following information:
   Name of institution: _____
   Address and phone # of institution (number and street): _____
   _____

please continue to the next page —

READ AND ANSWER THESE IMPORTANT QUESTIONS *(continued)*

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

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

Please contact Premera Blue Cross at 888-850-8526 (TTY: 711) if you need information in another format or language than what is listed above. Our office hours are seven days a week, between 8 a.m. and 8 p.m.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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

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

☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date here) _____.

☐ I recently was released from incarceration. I was released on (insert date here) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date here) _____.

☐ I recently obtained lawful presence status in the United States. I got status on (insert date here) _____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date here) _____.

☐ I am moving into, or live in a Long-Term Care Facility (for example, a nursing home or long term facility) (insert move in date) _____.

☐ I am moving out of a Long-Term Care Facility (for example, a nursing home or long term facility) (insert move out date) _____.

☐ I recently left a PACE program (insert date here) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date here) _____.

☐ I am leaving employer or union coverage on (insert date here) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, OR Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date here) _____.

☐ I was impacted by a significant network change with my current plan and was notified on: (insert date here) _____.

☐ Other: _____.

If none of these statements applies to you or you're not sure, please contact Premera Blue Cross at 888-868-7767 (TTY: 711) to see if you are eligible to enroll. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., from October 1–February 14).

please continue to the next page —

STOP

PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining Premera Blue Cross could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Premera Blue Cross. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:

Premera Blue Cross is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Premera Blue Cross serves a specific service area. If I move out of the area that Premera Blue Cross serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Premera Blue Cross, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Premera Blue Cross when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Premera Blue Cross Medicare Advantage (HMO) or Premera Blue Cross Medicare Advantage Classic (HMO) or Premera Blue Cross Medicare Advantage Classic Plus (HMO) coverage begins, I must get all of my health care from Premera Blue Cross Medicare Advantage Network Providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Premera Blue Cross and other services contained in my Premera Blue Cross Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PREMERA BLUE CROSS WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Premera Blue Cross, he/she may be paid based on my enrollment in Premera Blue Cross.

Release of Information:

By joining this Medicare health plan, I acknowledge that Premera Blue Cross will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Premera Blue Cross will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: Today's Date:

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone: ( ) Relationship to Enrollee:

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