2022 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 Download Application Summary of Benefits Provider Search Pharmacy Search Formulary

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: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2022 (Pending)

Section 1 – All fields on this page are required

(unless marked optional)

All plans include preventive and comprehensive dental.

SELECT THE PLAN YOU WANT:

KING • PIERCE • SNOHOMISH • THURSTON • WHATCOM

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $55**
- ☐ **Classic Plus (HMO) - $170** (not available in Whatcom)
- ☐ **Peak + Rx (HMO) - $0**
- ☐ **Sound + Rx (HMO) - $35**
- ☐ **Charter + Rx (HMO) - $110**
- ☐ **Alpine (HMO) - $24** (no prescription coverage)

LEWIS • KITSAP • COWLITZ • ISLAND • SAN JUAN • SKAGIT

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $55**

SPOKANE • WALLA WALLA

- ☐ **HMO - $0**
- ☐ **Classic (HMO) - $55** (not available in Spokane)
- ☐ **Total Health (HMO) - $24**

STEVENS

- ☐ **Total Health (HMO) - $24**

YOUR INFORMATION

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

Birth Date: Sex: ☐ M ☐ F Phone:

Email Address: Send materials electronically: ☐ Yes ☐ No

Permanent residence (PO box is not allowed)

Street Address: City:

Optional: 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 use your Medicare card to complete this section.

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

––– OR –––

- Attach a copy of your Medicare card 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.

Name (as it appears on your Medicare card):

Medicare #:

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 ☐ APP MAILED TO AGENT ☐ SEMINAR (DATE / LOCATION):		AGENT RECEIVED DATE: EFFECTIVE DATE: SEP TYPE:	
PBP:	PLAN #:	CONTRACT #:	GROUP #:

OFFICE USE ONLY

READ AND ANSWER THESE IMPORTANT QUESTIONS

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

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

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

Name of other coverage: _____

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

Section 2 - All fields on this page are optional

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

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

Select one if you want us to send you information in an accessible format. ☐ Braille

Contact Premera Medicare Advantage at 888-868-7767 (TTY/TDD:711) if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., October 1–March 31).

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

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Premera Blue Cross.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Premera Blue Cross will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that I must get all of my medical and prescription drug benefits from Premera Blue Cross when my coverage begins on one of the following plans: Premera Blue Cross Medicare Advantage (HMO), or Premera Blue Cross Medicare Advantage Classic (HMO), or Premera Blue Cross Medicare Advantage Classic Plus (HMO), or Premera Blue Cross Medicare Advantage Total Health (HMO), or Premera Blue Cross Medicare Advantage Peak + Rx (HMO), or Premera Blue Cross Medicare Advantage Sound + Rx (HMO), or Premera Blue Cross Medicare Advantage Charter + Rx (HMO), or Premera Blue Cross Medicare Advantage Alpine (HMO) coverage.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

  1) This person is authorized under state law to complete this enrollment, and

  2) Documentation of this authority is available upon request by Medicare.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

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

Name: _____ Phone number: _____

Address: _____

Relationship to Enrollee: _____

Paying your plan premiums

You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe by mail or electronic funds transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

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

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.)

I get monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

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

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

- ☐ I am new to Medicare.
- ☐ I am enrolling during the Annual Enrollment Period from October 15 through December 7.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on _____.
- ☐ I recently returned from incarceration. I was released on _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____.
- ☐ I recently obtained lawful presence status in the United States. I got status on _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____.
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on _____.
- ☐ I am moving into, live in, or recently moved out of a long-term care facility (for example: a nursing home or long-term care facility). I moved/will move into/out of the facility on _____.
- ☐ I recently left a PACE program on _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's coverage). I lost my drug coverage on _____.
- ☐ I am leaving employer or union coverage on _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, OR Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____.
- ☐ I was impacted by a significant network change with my current plan and was notified on: _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of a natural disaster.

If none of these statements applies to you or you're not sure, please contact Premera Blue Cross at 888-868-7767 (TTY/TDD: 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–March 31).