



PREFERRED PLAN



NORTH CAROLINA

ENROLLMENT

KIT

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The AAA Carolinas Preferred Plan offers valuable health care coverage that is secondary to Medicare and includes additional Dental, Vision, and Hearing benefits. Plus, enjoy value-added programs like the Silver&Fit® Exercise and Healthy Aging Program*, a 24-Hour Nurse Advice Line, and a prescription drug discount card, all at no additional cost to you. Apply today!

This enrollment kit contains important information and forms needed to submit your application for health care coverage.

KIT CONTENTS:

- **Plan Overview / Premium Information**

FORMS TO COMPLETE:

- **Enrollment Application**
(Required) - Carefully review, complete and sign all portions
- **Authorization for Premium Collection (Bank Draft) Form**
- **Conditional Receipt**
(Required) - Your receipt for your first month's premium; explains that payment does not guarantee coverage

*For questions or additional assistance, please contact your agent or call AAA Carolinas Preferred Plan Customer Service at **1-877-286-5656 (TTY 711)**, 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday.*

When applying for the AAA Carolinas Preferred Plan, you will need to provide evidence of an active AAA Carolinas membership. This could include a copy of a current membership card or membership number from online or telephone enrollment.

*If you are not currently a member of AAA Carolinas, sign up today! Go to www.joinaaanow.com and enter promotional code **MEDSUP**.*

*Silver&Fit is a federally registered trademark of American Specialty Health Incorporated and used with permission herein.



CarolinAs **PREFERRED PLAN**

Your valued AAA Carolinas membership offers affordable and exclusive health coverage. This Preferred Plan provides basic and additional benefits that are secondary to Medicare Parts A and B.

Basic Benefits

- Part A Hospitalization
 - Days 61-90 Coinsurance
 - Lifetime Reserve Days 91-150 Coinsurance
 - 365 More Days beyond Lifetime Reserve
- Part A Hospice Coinsurance
- Part B Coinsurance
- Parts A & B Blood

Additional Benefits

- Part A Deductible
- Part B Deductible
- Skilled Nursing Facility
 - Days 21-100 Coinsurance
- Part B Excess Charges
- Foreign Travel Emergency

Cost sharing applies, see benefit details on back.

Dental, Vision and Hearing Benefits

AAA Carolinas Preferred Plan provides you with benefits beyond what is offered with original Medicare.

- Dental Care with coverage up to \$250 per year for any dental related expenses, can be used as secondary payment for other Dental coverage
- Vision Care coverage up to \$250 each year, covers exams, eyewear or contacts
- Hearing coverage up to \$250 each year, covers hearing exams and hearing aids

Choose Your Doctors and Hospitals

You are free to select the doctors and hospitals you prefer – no need to change providers because of network restrictions. And there are no referrals required to see a specialist.

Travel Benefits

- Within the U.S. – the plan is portable and can be used in other states when you travel
- Foreign Travel – includes coverage for emergency treatment while traveling outside the U.S.

24-Hour Nurse Advice Line

You will have access to a 24-hour Nurse Advice Line. This program allows you to call toll-free to speak with a registered nurse 24 hours a day, seven days a week to answer your health-related questions.

Silver&Fit® Exercise and Healthy Aging Program*

Enjoy a membership to participating fitness facilities nationwide or request at-home fitness kits, at no additional charge.

AAA Carolinas Rx Perks** prescription drug discount card

- Average savings of 31% on prescription drugs (based on 2010 program savings data)
- Discounts available for the entire household – even pets!
- Save on wellness services including vision care, hearing care and daily living products

Customer Service

When you need us, call our Customer Service department at **1-877-286-5656 (TTY 711)**. Our experienced Customer Service specialists can handle questions on claims, covered benefits, or anything related to your plan.

*Silver&Fit is a federally registered trademark of American Specialty Health Incorporated and used with permission herein.

**DISCOUNT ONLY – NOT INSURANCE. Administered by Medical Security Card Company, LLC . You do not have to enroll in any health plan to accept this offer.

BENEFIT DETAILS

| 2012 OUT-OF-POCKET COSTS | | |
|---|---|---|
| COVERED BENEFIT | WITH ORIGINAL MEDICARE ALONE YOU PAY | WITH AAA CAROLINAS PREFERRED PLAN YOU PAY |
| PLAN DEDUCTIBLE | | \$250 Plan Deductible applies before benefits for Part A or Part B will be paid |
| PART A - HOSPITAL INSURANCE | | |
| WHEN YOU ARE HOSPITALIZED FOR: | | |
| DAYS 1-60 | \$1,156 deductible each hospital stay | \$100 inpatient copay for days 1-5, then \$0 |
| DAYS 61-90 | \$289 per day | \$0 |
| DAYS 91-150 | \$578 per day | \$0 |
| EACH DAY BEYOND 150 DAYS | All costs | \$0 for an additional 365 days |
| SKILLED NURSING FACILITY CARE | Up to \$144.50 each day, days 21-100 | \$0, days 21-100 |
| HOSPICE | No more than \$5 for each prescription drug for pain relief and symptom control; 5% of Medicare-approved amount for inpatient respite care. | \$0 |
| PART B - MEDICAL INSURANCE | | |
| PART B DEDUCTIBLE | \$140 each year | \$0 |
| PART B (MEDICAL) COINSURANCE | 20% of the Medicare-approved amounts | \$10 copay Primary Care Office visit \$20 copay Specialist Office visit \$50 copay Emergency Room (if admitted, copay waived and benefits covered under Part A) |
| FIRST 3 PINTS OF BLOOD EACH YEAR | 100% of the Medicare-approved amounts | \$0 |
| PART B EXCESS CHARGES | All costs | \$0 |
| NOT COVERED BY MEDICARE | | |
| FOREIGN TRAVEL EMERGENCY | All costs | \$250 deductible, then 20% of remaining charges up to \$50,000 maximum lifetime benefit |

ADDITIONAL BENEFITS (A COMBINED VALUE UP TO \$750): DENTAL CARE, VISION AND HEARING

North Carolina PREMIUMS

| AGE | 65-69 | 70-74 | 75-79 | 80+ |
|---------------|---------|----------|----------|----------|
| FEMALE | \$96.32 | \$110.48 | \$124.04 | \$132.98 |
| MALE | \$96.44 | \$120.20 | \$139.57 | \$156.72 |

This is a solicitation of insurance. Contact may be made by an authorized representative. For AAA Carolinas Preferred Plan, neither Sterling nor its agents are connected with or endorsed by the United States government or the federal Medicare program. This policy may have limitations, exclusions or reductions of benefits. Please see Certificate of Coverage for complete details. For costs and complete details of coverage, contact Sterling.

STERLING LIFE INSURANCE COMPANY

Administration/Customer Service
P.O. Box 5348, Bellingham, WA 98227
(877) 286-5656

ENROLLMENT FORM FOR GROUP ASSOCIATION INSURANCE

| | | | |
|--|-------------|--------|---------------|
| 1. Enrollee Information. Print Enrollee's Full Name (Last, First & Middle Initial): | | | |
| Medicare I.D. # | Group Name: | | |
| AAA Member # | Age | Gender | Date of Birth |

Eligibility Status: Member Spouse of Member

Enrollment Period: Initial Enrollment Period Within 31 days of attaining Medicare eligibility

Plan Selection: AAA Carolinas Preferred Plan

Yes, I am insured under Medicare Part A and/or B Effective date for Part B _____

Permanent Residence:

| | | | |
|--------|-------|-----|-----------|
| Street | City | | |
| County | State | Zip | Telephone |

Billing Address: If different from permanent residence

2. Replacement of Coverage Information. To the best of your knowledge:

| | | | |
|--|---|-----------------------------|---|
| a. Do you have a Medicare supplement policy or certificate in force? If so, with which company? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insurer and Policy Number |
| b. Do you have any other health insurance coverage that provides benefits similar to this Member medical certificate? If so, with which company and what kind of policy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Company Name and Type of Policy |
| c. If the answer to a) or b) is yes, do you intend to replace your current Medicare supplemental policy or health insurance coverage with this certificate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| d. Are you covered for medical assistance through the state Medicaid program: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If Yes <input type="checkbox"/> | | | |
| | <input type="checkbox"/> As a "Specified Low-Income Medicare Beneficiary" (SLMB)? | | |
| | <input type="checkbox"/> As a "Qualified Medicare Beneficiary" (QMB)? | | |
| | <input type="checkbox"/> For other Medicaid medical benefits? | | |

3. Acknowledgments. The Enrollee, to the best of his/her knowledge and belief, represents and agrees as follows:

1. That the statements contained in the enrollment form are complete, true and correct.
2. No other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
3. Insurance issued as a result of this enrollment form will take effect as specified in the Receipt.
4. Plan provisions concerning exceptions, exclusions, limitations and renewal, which have been applied for, have been explained and are understood.

4. Representation. The undersigned enrollee acknowledges that the enrollee has read or had read to him/her the completed enrollment form and that he/she realized that any false statements or misrepresentation therein may result in loss of coverage under the certificate.

5. Payment of Premium. Read the receipt before signing. This is to acknowledge that I have read the receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of this receipt

6. Authorization. In connection with an application for insurance currently made to Sterling, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization shall be valid for a period of two years and six months from the date signed.

I further authorize Sterling, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Health Care Financing Administration, or its duly appointed Part A or Part B carriers, or intermediaries, to release to Sterling information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include EOMBs, "deduct-not-met" or denial letter, Part B billing forms, and information date of enrollment in Part B of Medicare. I further authorize ongoing release of this information to Sterling for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Sterling in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, that I will need to fill out claims forms and some records could be released before the rescission has time to take effect.

Sterling does not consider any information obtained from genetic screening or testing in processing an application for coverage for health care services under an individual or group policy, contract, or agreement or in determining insurability under such a policy, contract, or agreement. Sterling does not inquire, directly or indirectly, into the results of genetic screening or testing or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, an individual or group policy, contract, or agreement. As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

Dated at City _____ State _____ Zip _____

Enrollee's Signature: _____ Date _____

NOTICE. Any person who includes any false or misleading information on an application for an insurance policy may be subject to criminal and civil penalties.

Agent Signature _____ Agent I.D. _____ Date _____



Carolinas **PREFERRED PLAN**

Authorization for Automated Premium Collection (APC)

As a convenience to me, I authorize Sterling Life Insurance Company (Sterling) to initiate debit entries to the bank account listed below. This withdrawal from my bank account will pay for coverage of health care benefits under the:

AAA Carolinas Preferred Plan

Please provide the following bank information and attach a voided check

Bank From Checking Savings

City State

Accountholder Name

Routing # Account #

Where is my Accountholder Name, Routing number and Account number?

| | | |
|--------------------------------|--|--------------------------------|
| Account Number 000123456789 | | Accountholder Name John Doe |
| Routing Number 123456789 | | |

I understand this withdrawal will occur by the 12th business day each month **for premium due the month of the withdrawal**, or by the last business day each month **for premium due the month following the month of withdrawal**, depending on the draft date option selected below, and that such record will appear on my monthly bank statement.

Draft Date: ACH 5 **(by the 12th)** or ACH 20 **(by the 30th)**

I understand my bank account will be debited for my initial premium on or before the effective date of coverage. I agree that if any charge is dishonored it may result in forfeiture of insurance. I understand I remain obligated to make my monthly premium payment in the event my Bank does not transfer the necessary funds.

I hereby authorize Sterling to begin withdrawing premiums from my bank account as indicated above. I understand that I have the right to stop the automatic deduction by notifying my bank at any time or by written notification to Sterling at least 10 business days prior to the day premiums are due (1st of the month). I understand that this agreement will remain in effect until Sterling has received written notice from me or I disenroll.

Last Name First Name Middle Initial

Medicare Number

Enrollee Signature

Today's Date
MM DD YYYY

Accountholder Signature

Today's Date
MM DD YYYY

You may now have your premium automatically withdrawn from you credit or debit card. We currently are accepting Visa, MasterCard and Discover credit cards and debit cards with the Visa or MasterCard logos. Please contact customer service at 1-877-286-5656 or TTY 711 for more information.



Carolinas **PREFERRED PLAN**

Conditional Receipt

Health Plan Operations
P.O. Box 5348, Bellingham, WA 98227-5348
1-877-286-5656

8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday

Payment of first month's premium does not provide insurance coverage until a policy is issued to you by Sterling Life Insurance Company.

Upon Sterling Life Insurance Company's receipt of your AAA Carolinas Preferred Plan Application, the first premium, and our verification of your eligibility, you will be notified of the effective date of your enrollment.

If an application is declined or withdrawn, the premium for such application will be returned to the remitter. If a check or draft is given in payment, this receipt will be void if the check or draft is not paid upon presentation.

Should you have any questions concerning your application, please contact us at the administrative office listed above.

Plan Type

Mode of Payment:

- Monthly: Coupon Automated Premium Collection (Bank Draft)
Statement: Quarterly Semi-Annually Annually

First Premium Received \$

Check #

Money Order #

Receipt Issued To:

X

Signature of Agent

Date



PREFERRED PLAN

Underwritten by Sterling Life Insurance Company

2219 Rimland Drive • Bellingham, WA 98226