MASSACHUSETTS

# Medicare HMO Blue SaverRx (HMO)
# Medicare HMO Blue ValueRx (HMO)
# Medicare HMO Blue FlexRx (HMO-POS)
# Medicare HMO Blue PlusRx (HMO)

**2020**

## To Complete Your Enrollment Form:

Be sure to complete all information, sign, and date your enrollment form. Please keep a copy of the enrollment form for your records. Return the completed form(s) in the enclosed envelope. If you lose the return envelope, mail your application to: **Blue Cross Blue Shield of Massachusetts, Enrollment Department, P.O. Box 55011, Boston, MA 02205**. We will contact you in writing when we receive your enrollment form, and then again to notify you of your effective date.

**To enroll in Medicare HMO Blue SaverRx, Medicare HMO Blue ValueRx, Medicare HMO Blue FlexRx, or Medicare HMO Blue PlusRx, Please Provide the Following Information:**

| | Medicare HMO Blue SaverRx | Medicare HMO Blue ValueRx | Medicare HMO Blue FlexRx | Medicare HMO Blue PlusRx |
|---|---|---|---|---|
| Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties | ☐ $0 per month | ☐ $36 per month | ☐ $96 per month | ☐ $266 per month |
| Worcester County | ☐ $0 per month | ☐ $56 per month | ☐ $106 per month | ☐ $266 per month |

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Initial | Mr. Mrs. Ms.<br>☐ ☐ ☐ |
| Birth Date (MM/DD/YYYY)<br>/ / | Sex<br>☐ M ☐ F | Email Address | Home Phone Number<br>( ) – |
| Permanent Residence Street Address (P.O. Box is not allowed)<br>Number and Street | | | Alternate Phone Number<br>( ) – |
| City | | State | Zip Code |
| Mailing Address (only if different from your Permanent Residence Address)<br>Number and Street | | | |
| City | | State | Zip Code |
| Emergency Contact Name | Phone Number | Relationship to You | |

**Please Provide Your Medicare Insurance Information**

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

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

| | |
|---|---|
| Name (as it appears on your Medicare card): | |
| Medicare Number: | |
| Is Entitled to: | Effective Date: |
| Hospital (Part A) | |
| Medical (Part B) | |
| You must have Medicare Part A and Part B to join a Medicare Advantage plan. | |

## Paying Your Plan Premium

If you enroll in our $0 premium plan and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will send you a paper bill for your monthly late enrollment penalty. If you receive a paper bill and are interested in learning more about our alternative payment options, please contact our Member Service Department at **1-800-200-4255, (TTY: 711).**

For other plan options, you can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, 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, 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 Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx 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 co-insurance. 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 **1-800-772-1213.** TTY users should call **1-800-325-0778.** 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 bill monthly
- ☐ Electronic Funds Transfer (EFT) from your bank account each month. We will send you a brochure and form to enroll. (Please pay your premium by mail until you receive notification that your EFT payment option is activated.)
- ☐ Automatic deduction from your monthly
  - ☐ Social Security or
  - ☐ Railroad Retirement Board (RRB) benefit check

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

## Please Read and Answer These Important Questions

| | |
|---|---|
| 1. Do you have End Stage Renal Disease (ESRD)?<br>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. | Yes ☐ No ☐ |
| 2. 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 drug coverage in addition to Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx? | Yes ☐ No ☐ |
| If "yes," please list your other coverage and your identification (ID) number(s) for this coverage<br>Name of other coverage: | |
| ID# for this coverage: | |
| Group# for this coverage: | |
| 3. Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance? | Yes ☐ No ☐ |
| What kind of coverage? / Name of your insurance company | |
| 4. Are you a resident in a long-term care facility, such as a nursing home? | Yes ☐ No ☐ |
| If "yes", please provide the following information:<br>Name & Address of Institution: | |
| Phone Number of Institution: : ( ) | |
| 5. Are you enrolled in your State Medicaid program? | Yes ☐ No ☐ |
| If "yes", please provide your Medicaid Number: | |
| 6. Do you or your spouse work? | Yes ☐ No ☐ |

7. **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.
Please check any statement below that is true for you. We may contact you for additional information.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ 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) _____.

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

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

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

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ 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 (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ 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 (insert date)_____.

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

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

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

☐ 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 (insert date) _____.

☐ 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) _____.

☐ 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 the natural disaster.

If none of these statements applies to you or you're not sure, please contact Member Service at the number listed below to see if you are eligible to enroll

Please contact Member Service at the number listed below if you need information in an accessible format such as large print or braille.

| **Please choose the name of a Primary Care Provider (PCP):** | Please list your PCP's ID Number: | Yes ☐ | No ☐ |
|---|---|---|---|
| | Are you a current patient? | | |

Questions? Contact Member Service at **1-800-200-4255 (TTY: 711)**, 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, from Apr. 1 to Sept. 30; and 8:00 a.m. to 8:00 p.m. ET, 7 days a week, from Oct. 1 to Mar. 31.

## Please Read This Important Information

**If you currently have health coverage from an employer or union, joining Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx.** 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:**
Medicare HMO Blue SaverRx/ValueRx/ FlexRx/PlusRx 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.

Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx serves a specific service area. If I move out of the area that Medicare HMO Blue SaverRx/ValueRx/ FlexRx/PlusRx 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 Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx 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 Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx coverage begins, I must get all of my health care from Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx and other services contained in my Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MEDICARE HMO BLUE SAVERRX/VALUERX/FLEXRX/PLUSRX 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 Medicare HMO Blue SaverRx/ValueRx/ FlexRx/PlusRx, he/she may be paid based on my enrollment in Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Medicare HMO Blue SaverRx/ValueRx/FlexRx/PlusRx 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.

| **Your Signature** | **Today's Date** |
|---|---|
| | |

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

| **Name** | **Phone Number: (  )** |
|---|---|
| **Address** | **Relationship to Enrollee** |
| | |

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal. Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-425** (TTY: **711**).



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