BlueMedicare Rx℠ (PDP)

MedicareRx
Prescription Drug Coverage

BlueCross BlueShield of North Carolina
P.O. Box 17168
Winston-Salem, NC 27116-7168

2020 Individual Enrollment Form for Medicare Prescription Drug Plan

Please contact Blue Cross and Blue Shield of North Carolina (Blue Cross NC) if you need information in another language other than English or in an accessible format (Braille).

A. To enroll in Blue Medicare Rx (PDP), please provide the following information:

First Name: Middle Initial:

Last Name: Suffix:

Birth Date: (mm/dd/yyyy) / / Sex: ☐ Male ☐ Female

Primary Phone Number: - -

Alternate Phone Number: (optional) - -

Email Address: (optional)

Permanent Residence Street Address: (P.O. Box is not allowed)

City: State: Zip Code:

County:

Mailing Address: (only if different from your permanent residence address)

City: State: Zip Code:

Emergency Contact: (optional)

Relationship To You: Phone Number: - -

B. Please check which plan you want to enroll in:

Blue Medicare Rx (PDP)

☐ **Standard** (S5540-002): $ **89.60 per month**

☐ **Enhanced** (S5540-004): $ **121.40 per month**

C. 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.

Please note: You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name: (as it appears on your Medicare card)

_____

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Effective Date: (mm/dd/yyyy)

Hospital (Part A): ☐☐ / ☐☐ / ☐☐☐☐

Medical (Part B): ☐☐ / ☐☐ / ☐☐☐☐

D. Paying your plan premium:

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail 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 (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 or RRB benefit check or be billed directly by Medicare. DO NOT pay Blue Cross NC the Part D-IRMAA extra amount to Blue Medicare Rx.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify won't have a 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 ***ssa.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. If you have Medicare Part B, you must continue to pay your Medicare Part B premium if it is not otherwise paid for under Medicaid or by another third party.

Please select a premium payment option:

☐ Get a bill each month.

☐ Automatic deduction from your monthly Social Security benefit check.

☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

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Please note: 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.

☐ If you are a part of a list bill, please fill out the following:

Entity Name: _____ Group # ☐☐☐☐☐☐

E. Please answer the following question:

☐ Yes
☐ No

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 Blue Medicare Rx? **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: _____

F. Eligibility for an enrollment period:

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements carefully and check the box on the left 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.

☐ Annual Enrollment Period (AEP). Your plan effective date will be **January 1**.

☐ 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 the service area for my current plan **or** I recently moved and this plan is a new option for me.

I moved on: (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Where are you moving from:

County: _____ State: _____

Choose your plan's effective date: (mm/dd/yyyy) ☐☐ / 0 1 / ☐☐☐☐

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☐ 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 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: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I am moving into or live in a Long-Term Care Facility. (For example, a nursing home or long-term care facility.)

I moved/will move into facility on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently moved out of a Long-Term Care Facility. (For example, a nursing home or long-term care facility.)

I moved/will move out of facility on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently left a PACE program on:
(Programs of All-Inclusive Care for the Elderly)

I recently left a PACE program on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

☐ I recently involuntarily lost my creditable prescription drug coverage. (Coverage as good as Medicare's)

I lost my drug coverage on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ I am leaving employer or union coverage on:

(mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

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

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☐ I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

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

My plan is ending on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

My plan is with:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ 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 an SNP on: (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

Choose your plan's effective date: (mm/dd/yyyy)
☐☐ / 0 1 / ☐☐☐☐

☐ 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.

☐ None of these statements apply to me.*

Other Special Enrollment Period (SEP) reason:

_____

_____

* To see if you are eligible to enroll, please contact Blue Cross NC at: **1-800-661-5518** (TTY: 711), 7 days a week, 8 a.m. to 8 p.m. between October 1 – December 31; 8 a.m. to 6 p.m. Monday – Thursday and 8 a.m. to 5 p.m. on Fridays between January 1 – September 30.

G. Please read this important information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining Blue Cross NC, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

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If you currently have health coverage from an employer or union, joining Blue Cross NC could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Blue Cross NC. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

H. Applicant Agreement:

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,** 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: (mm/dd/yyyy)

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

Name:

Address:

City: State: Zip Code:

Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ Relationship to Enrollee:

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature: _____

Print Agent's Name: _____

Date Application Received: ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Telephone Number: _____ NPN#: (required) _____

Agent Number: _____

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Statement of Understanding

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

1. Blue Cross and Blue Shield of North Carolina is a PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Cross NC of any prescription drug coverage that I have or may get in the future.
2. I can only be in one Medicare prescription drug plan at a time - if I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Medicare Rx (PDP) will end that enrollment.
3. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 - December 7), unless I qualify for certain special circumstances.
4. Blue Medicare Rx (PDP) serves a specific service area. If I move out of the area that Blue Cross NC serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency when I cannot reasonably use Blue Medicare Rx (PDP) network pharmacies.
5. Once I am a member of Blue Cross NC, I have the right to appeal plan decisions about payment or services if I disagree.
6. I will read the Evidence of Coverage document from Blue Cross NC when I get it to know which rules I must follow to get coverage.
7. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
8. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Blue Cross NC, he/she may be paid based on my enrollment in Blue Cross NC.
9. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information

1. By joining this Medicare prescription drug plan, I acknowledge that Blue Medicare Rx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that Blue Cross NC 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.
3. 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.

If you prefer us to send you information in a language other than English or in another format (e.g., Braille, audio tape or large print): Please contact Blue Cross NC at: **1-800-661-5518** (TTY: 711), 7 days a week, 8 a.m. to 8 p.m. between October 1 – December 31; 8 a.m. to 6 p.m. Monday – Thursday and 8 a.m. to 5 p.m. on Fridays between January 1 – September 30.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
Email: civilrightscoordinator@bcbsnc.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-Privacy, Ethics & Corporate Policy Office 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:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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Multi-Language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。

顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTION。: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM:Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ ક ઉપલ ધ છે. તમારા સ ચપદ ઓળખપ રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណាំ៖ ប្រសិនប្រហោកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយម្កភាសាមានផ្តល់ជូនសបមាប្រហោកអ្នកហោយមិនគិតថ្លៃ។សូមហៅហៅកា ន់បសវាអតិជនហោយបប្របលទូរស័ព្ទហៅខាងក្នងកាតសមាជិករបស់ហោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

注意：如果您講廣東話或普通話，　您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服或TTY號的電話號碼。

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