BlueCross BlueShield of North Carolina

MedicareRx Prescription Drug Coverage

PO Box 17168
Winston Salem, NC 27116-7168

BlueMedicare Rx℠ (PDP)

2017 Individual Enrollment Form for Medicare Prescription Drug Plan

Please contact BCBSNC if you need information in another language or format (Braille).

A. To enroll in BCBSNC, please provide the following information:

First Name *Middle Initial* *Last Name* *Jr., Sr.*

Birth Date (MM/DD/YYYY) / /

Sex
☐ Male
☐ Female

Home Phone Number - -

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

City State Zip Code

County

Alternate Phone Number *(Optional)* - -

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

City State Zip Code

Emergency Contact *(Optional)*

Relationship To You

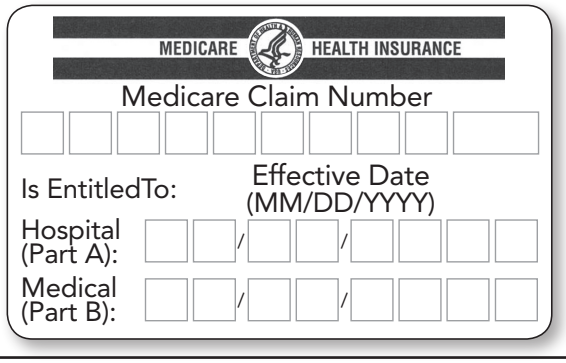
Phone Number - -

B. Please check which plan you want to enroll in

Blue Medicare Rx
☐ Standard.....$ 67.00 per month
☐ Enhanced .....$ 124.00 per month

C. Please provide your Medicare insurance information

Please take out your Medicare card and complete this section. Please fill in these 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 or Part B (or both) to join a Medicare Prescription drug plan.

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 benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by 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 Railroad Retirement Board benefit check or be billed directly by Medicare. DO NOT pay BCBSNC 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 co-insurance. 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 ***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. If you have Medicare Part B, you must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

☐ Receive a bill each month.

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board 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

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 drug coverage in addition to Blue Medicare Rx?

   ☐ 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 _____

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 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.

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

☐ I am new to Medicare. Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ 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)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

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

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

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

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ I no longer qualify for extra help paying for my Medicare prescription drug coverage.

I stopped receiving extra help on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ 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 out of the facility on:

☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

☐ I recently left a PACE program on: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

Please choose an effective date: ☐☐ / ☐☐ / ☐☐☐☐
(MM/DD/YYYY)

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

I lost my drug coverage on: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

☐ I am leaving employer or union coverage on: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

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

__ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

☐ 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)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

☐ 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)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

My plan is with: ______________________________

☐ I am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on:

__ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

Please choose an effective date: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)

☐ None of these statements applies to me.*

Other SEP reason: ______________________________

*Please contact BCBSNC at **1-800-661-5518** to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m., 7 days a week. TTY users should call **1-800-922-3140**.

G. Applicant Agreement

I understand that my signature (or the signature of the person authorized to act on my behalf under the State law of 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 or by 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 ☐☐☐ - ☐☐☐ - ☐☐☐☐ Relationship to Enrollee

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 BCBSNC at **1-800-661-5518**. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users should call **1-800-922-3140**.

LICENSED AGENT USE ONLY

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

Agent's Signature _____ Date App Received _____

Print Agent's Name _____ Telephone Number _____

Agent Number _____ NPN# (required) _____

STOP 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 BCBSNC, 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.

If you currently have health coverage from an employer or union, joining BCBSNC could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCBSNC. 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.

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 BCBSNC 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 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 serves a specific service area. If I move out of the area that BCBSNC 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 network pharmacies.
5. Once I am a member of BCBSNC, 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 BCBSNC 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 BCBSNC, he/she may be paid based on my enrollment in BCBSNC.
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 will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
2. I also acknowledge that BCBSNC 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.

BlueMedicare Rx℠ (PDP)

Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-661-5518 (TTY: 1-800-922-3140).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-661-5518 (TTY: 1-800-922-3140).

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。請致電 1-800-661-5518 (TTY：1-800-922-3140）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-661-5518 (TTY: 1-800-922-3140).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-661-5518 (TTY: 1-800-922-3140) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-661-5518 (ATS : 1-800-922-3140)

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-661-5518.
المبرقة الكاتبة: 1-800-922-3140.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-661-5518 (TTY: 1-800-922-3140).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-661-5518 (телетайп: 1-800-922-3140).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-661-5518 (TTY: 1-800-922-3140).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્કુ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-661-5518 (TTY: 1-800-922-3140).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-800-661-5518 (TTY: 1-800-922-3140)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-661-5518 (TTY: 1-800-922-3140).

ध्यान दें: यदि आप हिदी बोलते ह हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-661-5518 (TTY: 1-800-922-3140) पर कॉल करें।

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Multi-language Interpreter Services *(continued)*

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-661-5518 (TTY: 1-800-922-3140).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-661-5518（TTY: 1-800-922-3140）まで、お電話にてご連絡ください。

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BlueMedicare Rx℠ (PDP)

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:

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

- If you need these services, contact Customer Service at 1-800-661-5518. TTY call 1-800-922-3140, 8 a.m. to 8 p.m. daily.
- If you believe that BCBSNC 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:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783 civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. 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. Call Customer Service at 1-800-661-5518, 1-800-922-3140 (TDD).

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