2017 PacificSource Medicare Advantage Plan Information

Thank you for your interest in applying for the PacificSource 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 PacificSource within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating: HMO / PPO
Apply Online
Download Application: Central OR / Coos & Curry / Lane County / PDX
Summary of Benefits: Essentials 2 / Essentials RX 6 / Essentials Choice Rx 14 / Essentials RX 26 / Explorer RX 4 / Explorer RX 7 / Explorer 8 / MyCare Rx 22
Provider Directory
Formulary
Appeals and Grievance information
Low Income Subsidy
Multi-language Support

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: http://www.orhi.us

PacificSource Medicare

PacificSource Community Health Plans
2965 NE Corners Avenue, Bend OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

2017 Medicare Advantage Enrollment Form
Central Oregon, Eastern Oregon, and Mid-Columbia Gorge

To enroll in a PacificSource Medicare plan, provide the following information

First Name	Last Name	MI	Sex ☐M ☐F	Requested Effective Date
Permanent Residence Street Address **(PO Box not allowed)**	City		State	ZIP Code
Mailing Address (only if different from above)	City		State	ZIP Code
Birth Date / /	Phone ( )	County	Email	
Name of Your Primary Care provider: First Name	Last Name		Established Patient? ☐ Yes ☐ No	

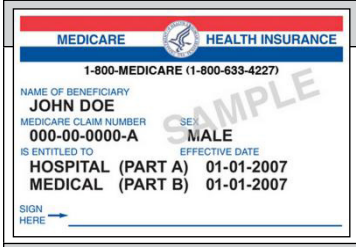
Already a PacificSource Medicare member? Please check the box below

☐ I have a PacificSource Medicare plan and want to change to a different PacificSource Medicare plan.

Check the plan you want to enroll in for 2017

☐ $127/mo Essentials Choice Rx 14 (HMO-POS)	☐ $205/mo Essentials Rx 6 (HMO)	☐ $122/mo Essentials Rx 27 (HMO)	☐ $42/mo Essentials 2 (HMO)

☐ Optional Supplemental Dental $28/mo in addition to your monthly plan premium above



Please provide your Medicare insurance information

Use your red, white, and blue Medicare card to complete this section. You must have **Medicare Part A and Part B** to join a Medicare Advantage plan.

Medicare Claim Number: _____

Please read and answer these important questions

1. Do you have End-Stage Renal Disease (ESRD)? ☐ YES ☐ NO
If "yes," and you've had a successful kidney transplant or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to get additional information.

2. Are you enrolled in your State Medicaid program? ☐ YES ☐ NO
If "yes," include your Medicaid number: _____

3. Have you had other <u>medical and/or prescription drug</u> coverage in the last 12 months? (i.e., other private insurance, TRICARE, federal employee health benefits, or VA benefits) ☐ YES ☐ NO

If "yes," include Effective Date: _____ Termination Date: _____

Subscriber Name: _____ Insurance Name: _____
Group Name: _____ ID Number: _____
Group Number: _____

Will you have other <u>medical and/or prescription drug</u> coverage in addition to your Medicare coverage and PacificSource Medicare? (i.e., other private insurance, TRICARE, federal employee health benefits, or VA benefits). ☐ YES ☐ NO If "yes," include Effective Date: _____

Termination Date: _____ Subscriber Name: _____
Insurance Company: _____ Group Name: _____
ID Number: _____ Group Number: _____

For agent use only:

Agent Name (Required): Tiffany Jackson
Agent ID (Required): PM 00173 Date Received by Agent (Required): _____

Please confirm your 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. If none of these statements apply to you or you're not sure, please contact Customer Service using the information in the Contact Information section on the back page.

Please read the following carefully and check the box if the statement applies to you. By checking any of the boxes you certify that, to the best of your knowledge, you're eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled. **Check all that apply**.

☐ I'm enrolling during the annual enrollment period (October 15–December 7).
☐ I'm new to Medicare.
☐ I recently moved outside the service area of my current plan, or recently moved and this plan is a new option for me. I moved on _____ (date).
☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
☐ I get Extra Help paying for Medicare prescription drug coverage effective (date) _____.
☐ I no longer qualify for Extra Help paying for my Medicare prescription drugs. I stopped receiving Extra Help on _____ (date).
☐ I'm moving in, live in, or recently moved out of a Long Term Care Facility (i.e., nursing home). I moved or will move in on _____ (date) or moved/will move out on _____ (date).
☐ I recently left a PACE program on _____ (date).
☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on _____ (date).
☐ I'm leaving employer or union coverage on _____ (date).
☐ I belong to a pharmacy assistance program provided by my state.
☐ I recently returned to the United States after living permanently outside of the United States. I returned to the United States on _____ (date).
☐ I recently obtained lawful presence status in the United States. I got this status on _____ (date).
☐ I recently was released from incarceration. I was released on _____ (date).
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
☐ I was enrolled in a Special Needs Plan (SNP) but have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ (date).
☐ None of the above statements apply to me. I feel I have a special circumstance which allows me an exception to enroll. Please include the reason: _____

Please read all sections of this document before signing

Signature: _____ **Today's Date**: _____

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other _____

If you are the authorized representative *and* you signed this form, complete the following:

Name: _____ Address: _____

Phone Number: _____ Relationship to Enrollee: _____

You understand your signature (or the signature of the person authorized to act on my behalf under the laws of the State where you live) on this application means you 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.

Paying your plan premium

You can pay your monthly plan premium (optional dental benefits, and any late enrollment penalty you have or may owe) with one of the options below. *Note: If you don't select an option, we'll keep your current option or send you a bill.*

☐ **Automatic deduction from your checking account each month. Please include a voided check.**

Automatic deductions are made on the 5th day of every month. Deductions include any outstanding balance on your account. If the deduction falls on a weekend or holiday, the deduction will occur the next business day. Funds can only be deducted from checking accounts. Please provide a voided check (deposit slips not accepted). You can stop deductions from your account by notifying us at the phone number or address on page 1 at least 30 days prior to the deduction date.

☐ **Credit card.** Once you're enrolled, we'll send you information about setting up credit card payments.

Payment options continued on next page

☐ **Automatic deduction from your Social Security or Railroad Retirement Board (RRB) check.***

☐ **Get a monthly bill**.

*(The Social Security/RRB deduction may take two or three 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.)

Important information about paying your plan premium

If you have 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 monthly premium. You can either choose to have the amount withheld from your monthly Social Security check or be billed directly by Medicare or the Railroad Retirement Board (RRB). **DO NOT** pay PacificSource Medicare 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 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 Social Security at (800) 772-1213. TTY users should call (800) 325-0778. You can also apply for extra help online at 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.

Materials in Alternate Formats

Please check one of the boxes below if you would prefer us to send you information in another format:
☐ Braille ☐ Audio tape ☐ Large print

Please contact Customer Service toll-free at (888) 863-3637 or TTY users call (800) 735-2900, if you need information in another format than what is listed above. Our hours are listed in the Contact Information section.

Employer or union information

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

By completing this application, you agree to the following

We are a Medicare Advantage plan and have a contract with the Federal government. You will need to keep your Medicare Parts A and B. You can be in only one Medicare Advantage plan at a time, and you understand your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan. It is your responsibility to inform us of any prescription plan coverage you have or may get in the future.

You understand if you don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once you enroll, you 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.

You understand that we serve a specific service area. If you move out of the service area, you need to notify us so you can disenroll and find a new plan in your new area. Once you are a member of our plan, you have the right to appeal plan decisions about payment or services if you disagree. You will read the Evidence of Coverage (also known as a member contract or subscriber agreement) when you get it from us to know which rules you must follow in order to get coverage with this Medicare Advantage plan.

You understand services received outside the United States are not covered (except for urgent care, ambulance, emergency care, and out-of-area dialysis services). The Essentials Rx 27 plan provides coverage for urgent and emergency care within the U.S. only.

Continued on next page

You understand as an **Essentials (HMO) plan member** that beginning on the date your plan coverage begins, you must get all healthcare from in-network providers (these are providers we have a contract with), except for emergency, urgent care, or out-of-area dialysis services.

You understand as an **Essentials Choice (HMO-POS) plan member** that you have the option to receive services from either in-network or out-of-network providers. Coverage for out-of-network services for the **Essentials Choice Rx 14 (HMO-POS)** plan is limited to $2,500 per calendar year. Please see your Evidence of Coverage for additional information. Beginning on the date your coverage begins, using services with in-network providers can cost less than using services with out-of-network providers, except for emergency, urgent care, or out-of-network dialysis services.

If medically necessary, we provide refunds for all covered benefits, even if you get services with out-of-network providers. Services authorized by us and other services contained in your Evidence of Coverage (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither we nor Medicare will pay for the services**.

You understand if you get assistance from a sales agent, broker, or other individual employed by or contracted with us, he/she may be paid based on your enrollment in the plan.

Release of your information

By joining this Medicare health plan, you acknowledge PacificSource Medicare (we) will release your information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. You also acknowledge we will release your information including your prescription drug event data if you have a Medicare Advantage Part D plan 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 your knowledge. You understand if you intentionally provide false information on this form, you will be disenrolled from the plan.

Contact information

If you have questions, please contact us at:	Our hours are:
• (541) 385-5315 Bend • (888) 863-3637 Toll-free • (800) 735-2900 TTY	• October 1 to February 14: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. • February 15 to September 30: 8:00 a.m. to 8:00 p.m. local time zone, Monday–Friday.

Submit your completed enrollment form

Send completed enrollment forms to us at:

Fax: (541) 382-4217 or (855) 382-4217 toll-free

Email: medicareapplications@pacificsource.com

Mail: PacificSource Medicare
PO Box 7469
Bend, OR 97708

Enroll Online: Medicare.PacificSource.com

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource depends on contract renewal. You will need to keep your Medicare Parts A and B. You must continue to pay your Medicare Part B premium.