TUFTS Health Plan

PO Box 9178
Watertown, MA 02472

2018 TUFTS MEDICARE PREFERRED HMO INDIVIDUAL ENROLLMENT FORM

Please contact Tufts Health Plan Medicare Preferred if you need information in another language or format (Braille).

MASSACHUSETTS

TO ENROLL IN TUFTS MEDICARE PREFERRED HMO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Please check which plan you want to enroll in (The Tufts Medicare Preferred HMO Delta Dental® Option can only be elected along with a medical plan):

If You Live In: Barnstable, Bristol, Middlesex, Norfolk, Plymouth Counties			If You Live In: Hampden or Hampshire Counties		
☐ HMO Saver Rx	$0.00	per month	☐ HMO Basic Rx	$24.00	per month
☐ HMO Basic Rx	$46.00	per month	☐ HMO Value No Rx	$41.00	per month
☐ HMO Value No Rx	$103.00	per month	☐ HMO Value Rx	$70.00	per month
☐ HMO Value Rx	$132.00	per month	☐ HMO Prime No Rx	$67.00	per month
☐ HMO Prime No Rx	$133.00	per month	☐ HMO Prime Rx	$100.00	per month
☐ HMO Prime Rx	$166.00	per month	☐ HMO Prime Rx Plus	$132.00	per month
☐ HMO Prime Rx Plus	$200.00	per month			
Optional Supplemental Benefit:			Optional Supplemental Benefit:		
☐ Delta Dental® Option	$54.00	per month	☐ Delta Dental® Option	$54.00	per month
If You Live In: Essex or Suffolk Counties			**If You Live In: Worcester County**		
☐ HMO Saver Rx	$0.00	per month	☐ HMO Saver Rx	$0.00	per month
☐ HMO Basic No Rx	$38.00	per month	☐ HMO Basic No Rx	$40.00	per month
☐ HMO Basic Rx	$66.00	per month	☐ HMO Basic Rx	$68.00	per month
☐ HMO Value No Rx	$123.00	per month	☐ HMO Value No Rx	$112.00	per month
☐ HMO Value Rx	$152.00	per month	☐ HMO Value Rx	$147.00	per month
☐ HMO Prime No Rx	$156.00	per month	☐ HMO Prime No Rx	$152.00	per month
☐ HMO Prime Rx	$189.00	per month	☐ HMO Prime Rx	$186.00	per month
☐ HMO Prime Rx Plus	$221.00	per month			
Optional Supplemental Benefit:			Optional Supplemental Benefit:		
☐ Delta Dental® Option	$54.00	per month	☐ Delta Dental® Option	$54.00	per month

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __ /__ __ /__ __ __ __) (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )
Email Address:			
Permanent Residence Address (P.O. Box is not allowed):	City:	State:	Zip Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	Zip Code:
Preferred Written Language:	Preferred Spoken Language:		
Emergency contact:	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 we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it.

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail or 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 Railroad Retirement Board (RRB). DO NOT pay Tufts Health Plan Medicare Preferred 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 Each Month

☐ Electronic Funds Transfer (EFT) from your bank account each month

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check

I get monthly benefits from: ☐ Social Security ☐ RRB

(**The Social Security/RRB deduction may take two or more months to begin.** There may be a delay in withholding your premium due to SSA's monthly processing schedule, as the start date of premium withholding cannot be retroactive. If there is a delay, you will be billed directly for the first 1 - 2 months until your premium is deducted from your Social Security or RRB benefits check. You are responsible for paying all premiums due until premium withholding begins. If you do not pay your premium for the month(s) before premium withhold begins, you may be disenrolled from Tufts Health Plan Medicare Preferred. 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. Please choose a Tufts Medicare Preferred HMO Contracted Primary Care Physician (PCP):

_____

☐ Yes ☐ No Are you a current patient?

☐ Yes ☐ No 2. Do you have End-Stage Renal Disease (ESRD)?
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 3. 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 Tufts Medicare Preferred HMO?

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:

_____ _____ _____

☐ Yes ☐ No 4. Are you a resident in a long-term care facility, such as a nursing home? If "yes", please provide the following information:

Name of Institution: Address & Phone Number of Institution (number and street):

_____ _____

☐ Yes ☐ No 5. Are you enrolled in your State Medicaid program?
If "yes", please provide your Medicaid number: _____

☐ Yes ☐ No 6. Do you or your spouse work?

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.

☐ I am new to Medicare.

☐ 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 in the United States. I got this status on (insert 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.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)_____

☐ 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 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) _____

☐ Other Reason (Please describe Special Election Period) _____

_____

If none of these statements applies to you or you're not sure, please contact Tufts Health Plan Medicare Preferred at 1-877-409-3499 (TTY: 711) to see if you are eligible to enroll. We are open Monday - Friday 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 14, representatives are available 7 days a week 8:00 a.m. - 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

☐ Spanish ☐ Large Print

Please contact Tufts Health Plan Medicare Preferred at 1-877-409-3499 (TTY: 711) if you need information in another format or language than what is listed above. Our office hours are Monday - Friday 8:00 a.m. - 8:00 p.m. (From Oct. 1 - Feb. 14, representatives are available 7 days a week 8:00 a.m. - 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

STOP Please Read This Important Information

If you currently have health coverage from an employer or union, joining Tufts Medicare Preferred HMO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Tufts Medicare Preferred HMO. 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:

Tufts Health Plan Medicare Preferred 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Tufts Medicare Preferred HMO serves a specific service area. If I move out of the area that Tufts Medicare Preferred HMO 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 Tufts Medicare Preferred HMO I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Tufts Health Plan Medicare Preferred 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 Tufts Medicare Preferred HMO coverage begins, I must get all of my health care from Tufts Medicare Preferred HMO, except for emergency or urgently needed services or out-of-area dialysis services, and I must choose a primary care physician (PCP) and get a referral before seeing a specialist within my PCP's referral circle. If I obtain routine care from providers outside my PCP's referral circle neither Medicare nor Tufts Health Plan Medicare Preferred will be responsible for the cost. Services authorized by Tufts Medicare Preferred HMO and other services contained in my Tufts Medicare Preferred HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TUFTS HEALTH PLAN MEDICARE PREFERRED 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 Tufts Health Plan Medicare Preferred, he/she may be paid based on my enrollment in Tufts Medicare Preferred HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that Tufts Health Plan Medicare Preferred will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Tufts Health Plan Medicare Preferred 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.

Important: Your dental benefit and coverage plan is called the "Delta Dental Option," which requires members to seek services from providers in the Delta Dental PPO℠ network only. Your dental benefit under this plan **does not cover** dental services from Delta Dental providers who are outside of the PPO network or any out-of-network providers. For additional questions regarding this benefit or provider network, please contact customer service using the number listed on your card.

Signature:	Today's Date:

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

Name: _____ Address: _____

Phone Number: (____) _____ – _____ Relationship to Enrollee: _____

Office Use Only:

Name of staff member, agent, broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Enrollment Dept. Copy - White Member Copy - Yellow

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Tufts Health Plan at 1-800-701-9000 (TTY: 711).

If you believe that Tufts Health Plan 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:

Tufts Health Plan, Attention:

Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 1-888-880-8699 ext. 48000, (TTY number—711 or 1-800-439-2370. Español: 866-930-9252)
Fax: 617-972-9048
Email: OCRCoordinator@tufts-health.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator 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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-701-9000 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-701-9000 (رقم هاتف الصم والبكم: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-701-9000 (TTY 711)。

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
1-800-701-9000 (TTY: 711) فراهم می باشد. با تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-701-9000 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-701-9000 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-701-9000 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-701-9000 (TTY: 711).

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-701-9000 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-701-9000 (TTY: 711).

Japanese: 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。
1-800-701-9000 (TTY: 711）まで、お電話にてご連絡ください。

Khmer (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-701-9000 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-701-9000 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-701-9000 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1800-701-9000 (TTY: 711.)

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-800-701-9000 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-701-9000 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-701-9000 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-800-701-9000 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-701-9000 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-701-9000 (TTY: 711).