TUFTS Health Plan

P.O. Box 9178
Watertown, MA 02472

2021 Tufts Medicare Preferred HMO Short Enrollment Request Form.

A Personal information

First name:

Middle initial:

Last name:

Member ID number:

S 0 0

Primary phone number:

- -

Alternate phone number: (optional)

- -

☐ This is a mobile number

☐ This is a mobile number

Email address:

Permanent street address: (P.O. box is not allowed)

City:

State:

Zip code:

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

City:

State:

Zip code:

B Please provide your plan information

The chart below shows available plans for each service area and standard monthly plan premiums (**in bold**). The chart also shows plan premiums with the Tufts Health Plan Medicare Preferred Dental Option included (*in italics*). To enroll in the Tufts Health Plan Medicare Preferred Dental Option, complete the *Optional Supplemental Benefit* section below.

Barnstable, Bristol, Middlesex, Norfolk, and Plymouth Counties	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$17*
HMO Basic Rx (HMO)	**$46/month**	*$63*
HMO Value No Rx (HMO)	**$103/month**	*$133*
HMO Value Rx (HMO)	**$150/month**	*$180*
HMO Prime No Rx (HMO)	**$133/month**	*$163*
HMO Prime Rx (HMO)	**$180/month**	*$210*
HMO Prime Rx Plus (HMO)	**$214/month**	*$244*

Hampden and Hampshire Counties	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$17*
HMO Basic Rx (HMO)	**$35/month**	*$52*
HMO Value Rx (HMO)	**$73/month**	*$103*
HMO Prime Rx (HMO)	**$98/month**	*$128*
HMO Prime Rx Plus (HMO)	**$118/month**	*$148*

Essex and Suffolk Counties	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$17*
HMO Basic No Rx (HMO)	**$28/month**	*$45*
HMO Basic Rx (HMO)	**$61/month**	*$78*
HMO Value No Rx (HMO)	**$123/month**	*$153*
HMO Value Rx (HMO)	**$170/month**	*$200*
HMO Prime No Rx (HMO)	**$156/month**	*$186*
HMO Prime Rx (HMO)	**$203/month**	*$233*
HMO Prime Rx Plus (HMO)	**$235/month**	*$265*

Worcester County	Plan Premium	*With Dental Option*
HMO Saver Rx (HMO)	**$0/month**	*$17*
HMO Basic No Rx (HMO)	**$20/month**	*$37*
HMO Basic Rx (HMO)	**$43/month**	*$60*
HMO Value No Rx (HMO)	**$112/month**	*$142*
HMO Value Rx (HMO)	**$160/month**	*$190*
HMO Prime No Rx (HMO)	**$152/month**	*$182*
HMO Prime Rx (HMO)	**$195/month**	*$225*

Name of the plan you are currently a member of:

Tufts Medicare Preferred HMO _____

Current monthly premium:

$ _____

Name of the plan you would like to change to:

Tufts Medicare Preferred HMO _____

New monthly premium:

$ _____

Requested effective date:
(mm/dd/yyyy; must be in the future) ___ / **0 1** / _____

☐ **I understand that this plan has different health benefits and a different monthly premium. I have reviewed my new plan premium in the chart above.**

OPTIONAL SUPPLEMENTAL BENEFIT: Tufts Health Plan Medicare Preferred Dental Option

The Tufts Health Plan Medicare Preferred Dental Option can only be elected along with a medical plan. The Tufts Health Plan Medicare Preferred Dental Option is **$17 per month** for *HMO Saver Rx*, *HMO Basic Rx*, and *HMO Basic No Rx* plans. The Tufts Health Plan Medicare Preferred Dental Option is **$30 per month** for all other plans. The chart above shows plan premiums with the Tufts Health Plan Medicare Preferred Dental Option included (*in italics*).

☐ **Yes, I would like to add the Tufts Health Plan Medicare Preferred Dental Option.**

C Please choose a Tufts Medicare Preferred HMO contracted primary care physician (PCP)

If you don't have a PCP, we will automatically assign one to you. You can change your PCP at any time after you enroll.

Primary care physician:

Are you a current patient?

◯ Yes ◯ No

D Paying your plan premium

HMO Saver Rx plans only: If you are enrolling in a plan with a $0 premium, and 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 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.

Plans with monthly premiums: 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.

All plans: 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.

(If this option is selected, an *EFT Authorization Form* will be mailed to you. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.)

◯ Automatic deduction from your monthly Social Security benefit check.

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

The Social Security/RRB deduction may take two or more months to begin. There may be a delay in withholding your premium due to the Social Security Administration'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 benefit 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 withholding 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.

E Please select eligibility for 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. 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 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: (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 on: (mm/dd/yyyy) ___ / ___ / ____

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

I had this change on: (mm/dd/yyyy) ___ / ___ / ____

☐ 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.

☐ Other reason: (please describe Special Election Period)

_____

F Alternative languages and accessible formats

Preferred written language: _____

Preferred spoken language: _____

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

◯ Spanish ◯ Large print

*Please contact Tufts Health Plan Medicare Preferred at **1-800-701-9000 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. Representatives are available 8:00 a.m.–8:00 p.m., 7 days a week from October 1 to March 31 and Monday–Friday from April 1 to September 30.*

G Please read and sign below.

1. Tufts Health Plan Medicare Preferred is a plan that has a contract with the Federal government.
2. 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.
3. 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, and I must choose a primary care physician (PCP) and get a referral before seeing a specialist within my PCP's referral circle.
4. 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.
5. **Note to members also covered under VA Health Care:** To use VA benefits, you need to get care at a VA medical center or other VA locations, but you should not use your Tufts Health Plan Medicare Preferred ID card at the VA. You will use the Tufts Health Plan Medicare Preferred ID card when receiving services from Tufts Health Plan Medicare Preferred network providers (outside of the VA).
6. Dental benefits for members of Tufts Health Plan Medicare Preferred are administered by Dominion Dental Services, Inc. For questions regarding your benefits or provider network, please contact Customer Relations.

Release of Information

1. 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.
2. 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.
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.
4. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

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.

Signature: _____ Today's date (mm/dd/yyyy): ___ / ___ / ____

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

Full name:

Street address:

City: State: Zip code:

Phone number: ___ - ___ - ____ Relationship to Enrollee:

OFFICE/BROKER USE ONLY

Name of staff member/agent/broker, if assisted in enrollment: (please print)

Agent NPN:

Date application received (mm/dd/yyyy): / /

Effective date of coverage (mm/dd/yyyy): / /

Plan ID#:

Barnstable, Bristol, Middlesex, Norfolk, and Plymouth Counties		Hampden and Hampshire Counties		Essex and Suffolk Counties		Worcester County	
○ Saver Rx	**028/000**	○ Saver Rx	**028/000**	○ Saver Rx	**028/000**	○ Saver Rx	**028/000**
○ Basic Rx	**026/002**	○ Basic Rx	**026/003**	○ Basic No Rx	**042/000**	○ Basic No Rx	**041/000**
○ Value No Rx	**019/007**	○ Value Rx	**018/008**	○ Basic Rx	**026/001**	○ Basic Rx	**036/000**
○ Value Rx	**018/007**	○ Prime Rx	**015/006**	○ Value No Rx	**019/001**	○ Value No Rx	**040/000**
○ Prime No Rx	**016/002**	○ Prime Rx Plus	**001/006**	○ Value Rx	**018/001**	○ Value Rx	**034/000**
○ Prime Rx	**015/002**			○ Prime No Rx	**016/001**	○ Prime No Rx	**039/000**
○ Prime Rx Plus	**001/002**			○ Prime Rx	**015/001**	○ Prime Rx	**033/000**
				○ Prime Rx Plus	**001/001**		

Enrollment period:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP (type:) ☐ Not eligible

TUFTS Health Plan

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: 711)
Fax: 1-617-972-9048
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 (TDD: 1-800-537-7697)

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 (TTY: 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 1-800-701-9000 (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 (TTY: 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).