MASSACHUSETTS

2023

Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), Medicare PPO Blue PlusRx (PPO)

WHO CAN USE THIS FORM?

People with Medicare who want to join a Medicare Advantage plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the United States
- Live in the plan's service area

Important: To join a Medicare Advantage plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

WHEN DO I USE THIS FORM?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **medicare.gov** to learn more about when you can sign up for a plan.

WHAT DO I NEED TO COMPLETE THIS FORM?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional—you can't be denied coverage because you don't fill them out.

REMINDERS:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a P. O. Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

What happens next?

Send your completed and signed form to:

Blue Cross Blue Shield of Massachusetts
Enrollment Department
P.O. Box 55011
Boston, MA 02205

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Medicare PPO Blue SaverRx/ValueRx/PlusRx at **1-800-678-2265**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**.

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Section 1 – All fields in Section 1 are required (unless marked optional).

Select the plan you want to join:	☐ Medicare PPO Blue SaverRx	☐ Medicare PPO Blue ValueRx	☐ Medicare PPO Blue PlusRx
Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk Counties	$0 per month	$75 per month	$254 per month
Worcester County	$0 per month	$85 per month	$254 per month

FIRST name: LAST name: Middle Initial:

Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __) Sex: ☐ Male ☐ Female Phone number: ( ) -

Email (optional):

Permanent Residence (Don't enter a P. O. Box):

Street Address:

City: Optional: County: State: ZIP Code:

Mailing address, if different from your permanent address (P. O . Box allowed):

Street Address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: ___ ___ ___ ___ — ___ ___ ___ — ___ ___ ___ ___

Answer these important questions:

Will you have prescription drug coverage (like VA, TRICARE®) in addition to Medicare PPO Blue SaverRx/ValueRx/PlusRx? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Medicare PPO Blue SaverRx/ValueRx/PlusRx.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Medicare PPO Blue SaverRx/ValueRx/PlusRx will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.

- I understand that when my Medicare PPO Blue SaverRx/ValueRx/PlusRx coverage begins, I must get all of my medical and prescription drug benefits from Medicare PPO Blue SaverRx/ValueRx/PlusRx. Benefits and services provided by Medicare PPO Blue SaverRx/ValueRx/PlusRx and contained in my Medicare PPO Blue SaverRx/ValueRx/PlusRx "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Medicare PPO Blue SaverRx/ValueRx/PlusRx will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature: Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number: Relationship to enrollee:

Section 2 – All fields in Section 2 are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ I choose not to answer.

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White
- ❑ I choose not to answer.

☐ Check here if you want us to send you information in a language other than English.
Language:_____

☐ Check here if you want us to send you information in an accessible format.
Large print: _____

If you need information in an accessible format other than what's listed above, please call us at **1-800-200-4255.** We're open 8:00 a.m. to 8:00 p.m. ET, Monday-Friday, from April 1 to September 30; and 8:00 a.m. to 8:00 p.m. ET, seven days a week, from October 1 to March 31. TTY users can call **711**.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Provider of Choice (POC), clinic, or health center:

Paying your plan premiums

You have a choice in how to pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe). Please select a premium payment option below:

☐ Get a Bill Monthly

☐ Electronic Funds Transfer (EFT) from your bank account each month. We'll send you a brochure and form to enroll. (Please pay your premium by mail until you receive notification that your EFT payment option is activated.)

You can also choose to pay your premium by having it automatically taken out of your

☐ **Social Security,** or

☐ **Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Medicare PPO Blue SaverRx/ValueRx/PlusRx the Part D-IRMAA.

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of 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.

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

☐ 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: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I recently was released from incarceration. I was released on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I recently returned to the United States after living permanently outside of the United States I returned to the United States. on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I recently obtained lawful presence status in the United States. I got this status on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

continued

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

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ 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 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: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I recently left a PACE program on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

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

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I am leaving employer or union coverage on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ 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 plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan star ted on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ 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 fro m the SNP on:

Insert Date: (__ __ /__ __ /__ __ __ __)
(M M / D D / Y Y Y Y)

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

☐ I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.

If none of these statements applies to you or you're not sure, please contact Medicare PPO Blue SaverRx/ValueRx//PlusRx at **1-800-678-2265** (TTY users should call **711**) to see if you're eligible to enroll. We're open 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, from April 1 to September 30; and 8:00 a.m. to 8:00 p.m. ET, 7 days a week, from October 1 to March 31.

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal. Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

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