DO NOT TEAR. RETURN ENTIRE ENROLLMENT FORM.

# 2019 ENROLLMENT FORM

AULTCARE'S PRIMETIME HEALTH PLAN

## INSTRUCTIONS ON HOW TO ENROLL IN PRIMETIME HEALTH PLAN

**YOU MUST LIVE IN THE PRIMETIME HEALTH PLAN SERVICE AREA, WHICH IS:**

**CARROLL, COLUMBIANA, HARRISON, HOLMES, MAHONING, MEDINA, PORTAGE, STARK, SUMMIT, TRUMBULL, TUSCARAWAS AND WAYNE COUNTIES**

### 1 HAVE YOUR MEDICARE CARD AVAILABLE

You must have both Medicare Part A and Part B to enroll in PrimeTime Health Plan.

### 2 SIGN AND DATE THE ENROLLMENT FORM

This enrollment form is not complete until you or your authorized representative have signed and dated the form on page 5.

### 3 RETURN ENTIRE ENROLLMENT FORM

You will receive a Confirmation Letter once we receive confirmation of your enrollment from Centers for Medicare and Medicaid Services (CMS). Copies of your enrollment form are available upon request.

**You cannot have End-Stage Renal Disease at the time of enrollment, unless you do not need regular dialysis or have had a successful kidney transplant.**
***(certain exceptions may apply)***

## WOULD YOU LIKE FURTHER INFORMATION ON WHICH PRIMETIME HEALTH PLAN IS BEST FOR YOU?

**Call us at the numbers listed below or attend one of our informational meetings. Ask us for dates and times.**

IF YOU NEED ASSISTANCE AT ANY TIME, PLEASE CONTACT PRIMETIME HEALTH PLAN CUSTOMER SERVICE AT 330-363-7407 OR 1-800-577-5084 (TTY USERS SHOULD CALL 330-363-7460 OR 1-800-617-7446). OUR CALL CENTER IS OPEN MONDAY THROUGH FRIDAY FROM 8:00 a.m. TO 8:00 p.m., E.S.T. (OCTOBER 1ST – MARCH 31ST, WE ARE AVAILABLE 7 DAYS A WEEK, 8:00 a.m. TO 8:00 p.m., E.S.T.) OUR LOBBY IS OPEN MONDAY THROUGH FRIDAY 8:00 a.m. TO 4:30 p.m., E.S.T.

# 2019 ENROLLMENT FORM

AULTCARE'S PRIMETIME HEALTH PLAN

***PrimeTime Health Plan is a Medicare Advantage HMO-POS Plan***
***(Health Maintenance Organization (HMO) with a Point-of-Service (POS) option)***

## 1 PLEASE CHECK THE PLAN YOU WANT TO ENROLL IN:

***Premium Includes Prescription Drug Coverage***

- ☐ Aultimate Plan (HMO-POS) – 021 - **$0 per month**
- ☐ Classic Plan (HMO-POS) – 020 - **$39 per month**
- ☐ Plus Plan (HMO-POS) – 017 - **$89 per month**

***No Prescription Drug Coverage***

- ☐ Basic-MA Only Plan (HMO-POS) – 014 - **$0 per month**

***YOU MUST CONTINUE TO PAY YOUR MEDICARE PART B PREMIUM***

## 2 TO ENROLL IN PRIMETIME HEALTH PLAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____ JR/SR

Birth Date (mm/dd/yyyy): __ __ / __ __ / __ __ __ __ Sex: _____ Home Phone Number: _____

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

_____

City: _____ State: _____ Zip Code: _____

County: _____

Mailing Address *(Only if different from your Permanent Residence Address)*: _____

_____

City: _____ State: _____ Zip Code: _____

## 3 PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

**You <u>MUST</u> have Medicare Part A <u>AND</u> Part B to Join a Medicare Advantage Plan.**

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: _____

| **<u>Is Entitled To</u>** | **<u>Effective Date</u>** |
|---|---|
| HOSPITAL (Part A) | _____ |
| MEDICAL (Part B) | _____ |

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

## 4 YOUR PRIMARY CARE PHYSICIAN *(PrimeTime Health Plan network physician only):*

We request that all applicants include their primary care physician's name below. For an up-to-date listing of PrimeTime Health Plan Network Providers, visit www.primetimehealthplan.com.

Name of Primary Care Physician: _____

## 5 ADDITIONAL CONTACT INFORMATION (Optional):

Email Address: _____ Mobile Phone Number: _____

## 6 EMERGENCY CONTACT INFORMATION (Optional):

Name: _____ Phone: _____

Relationship to you: _____

## 7 PAYING YOUR PLAN PREMIUM:

**ZERO PREMIUM PLANS (With Prescription Drug Coverage):** 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 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 PREMIUMS:** You can pay your monthly plan premium (including any late enrollment penalty that you currently may 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.

**PLANS WITH PRESCRIPTION DRUG COVERAGE:** 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 the RRB. DO NOT PAY PRIMETIME HEALTH PLAN THE PART D-IRMAA.

**LIMITED INCOMES:** 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 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 the 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:**

- ☐ Receive a monthly bill
- ☐ Electronic Funds Transfer (EFT) from your bank account each month

  PLEASE ENCLOSE A VOIDED CHECK AND PROVIDE THE FOLLOWING:

  Account Holder Name: _____

  Bank Routing Number: _ _ _ _ _ _ _ _ _ Bank Account Number: _ _ _ _ _ _ _ _ _ _ _
- ☐ Automatic Deduction from your monthly Social Security 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 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.)

## 8 PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS:

1. Do you have End-Stage Renal Disease (ESRD)? ..... ☐ Yes ☐ No
   *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.*

2. 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 PrimeTime Health Plan? ..... ☐ Yes ☐ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of Coverage: _____ ID #: _____ Group #: _____

3. Are you enrolled in your State Medicaid Program? ..... ☐ Yes ☐ No

   If "yes", please provide your Medicaid Number: _____

4. Are you a resident in a long-term care facility, such as a nursing home?..... ☐ Yes ☐ No

5. Once enrolled in PrimeTime Health Plan, will you or your spouse work? ..... ☐ Yes ☐ No
   If "yes", is health care coverage provided? ..... ☐ Yes ☐ No
   If "yes", once enrolled, will you continue to carry this coverage? ..... ☐ Yes ☐ No
   If "yes", does the employer have 20 or more employees? ..... ☐ Yes ☐ No

## 9 CONFIRM YOUR 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.

*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.*

☐ I am enrolling during the Annual Enrollment Period, October 15-December 7.

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

☐ I am new to Medicare.

☐ I am leaving employer or union coverage. (insert date you will lose coverage or lost coverage): __ __ /__ __/ __ __ __ __ .

☐ 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 returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): __ __ / __ __ / __ __ __ __.

☐ 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): __ __ /__ __ /__ __ __ __.

☐ 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): __ __ /__ __ /__ __ __ __.

☐ 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 facility on (insert date): __ __ / __ __ / __ __ __ __ .

☐ I recently left a PACE program within the last two months. (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 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 started on (insert date): __ __ __ __ __ __ __ __ .

☐ 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): __ __ / __ __ / __ __ __ __.

☐ I was recently released from incarceration. I was released on (insert date):__ __ / __ __ / __ __ __ __ .

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date): __ __ / __ __ / __ __ __ __ .

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

**If none of these statements apply to you or you're not sure, please contact PrimeTime Health Plan at 330-363-7407 OR 1-800-577-5084 (TTY users should call 330-363-7460 OR 1-800-617-7446). Our Call Center is open Monday through Friday from 8:00 a.m. to 8:00 p.m., E.S.T. (October 1st - March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m., E.S.T.) Our Lobby is open Monday through Friday 8:00 a.m. to 4:30 p.m., E.S.T.**

## STOP PLEASE READ THIS IMPORTANT INFORMATION

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

**PLEASE READ AND SIGN ON PAGE 5**

**By completing this enrollment application, I agree to the following:**

PrimeTime Health Plan 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. [Basic-MA Only Plan: 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.

PrimeTime Health Plan serves a specific service area. If I move out of the area that PrimeTime Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new service area. Once I am a member of PrimeTime Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PrimeTime Health Plan 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 PrimeTime Health Plan coverage begins, I must get all of my health care from PrimeTime Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PrimeTime Health Plan and other services contained in my PrimeTime Health Plan Evidence of Coverage Document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PRIMETIME HEALTH PLAN 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 PrimeTime Health Plan, he/she may be paid based on my enrollment in PrimeTime Health Plan.

**Release of Information:** By joining this Medicare Health Plan, I acknowledge that PrimeTime Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PrimeTime Health Plan will release my information (Plans with prescription drug coverage: 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.

PrimeTime Health Plan, or a vendor on behalf of PrimeTime Health Plan, may contact you for demographic, satisfaction, and/or medical care management information in accordance with its obligations under Federal Law. (FCC TCPA Ruling 2015).

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: _____

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

Name: _____

Address: _____

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

*PrimeTime Health Plan is an HMO-POS plan with a Medicare Contract.*
*Enrollment in PrimeTime Health Plan depends on contract renewal.*

If you need information in another language or in an accessible format (like Braille, audiotape, or large print), please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 330-363-7460 or 1-800-617-7446). Our Call Center is open Monday through Friday from 8:00 a.m. to 8:00 p.m., E.S.T. (October 1st – March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m., E.S.T.)

**AGENT/BROKER USE ONLY:**

Name of Agent Assisting with Enrollment: _____

AultCare Writing Code: _____ Date: _____

Proposed Effective Date **(Subject to CMS approval):** _____

**PRIMETIME ELIGIBILITY USE ONLY:**

Election: ICEP (I) ____ IEP (E) ____ SEP ____ MA OEP _____ AEP _____ OEPI _____

Member ID No: _____ Rep Initials: _____