2013 Enrollment Form

HMO-POS

To be eligible to enroll in PrimeTime Health Plan:

1. You must have Medicare Parts A and B.
2. You must live in the PrimeTime Health Plan service area, which is Carroll, Columbiana, Harrison, Holmes, Jefferson, Mahoning, Stark, Summit, Tuscarawas and Wayne counties.
3. 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.

Enrolling in PrimeTime Health Plan is easy:

1. Select the plan you want.
   a. If you don't know, learn more by attending one of our enrollment meetings. Call us for dates and times.
   b. Meet with one of our Marketing Representatives, if you need additional help or information.
2. Decide if you want to add the Optional Supplemental Dental/Vision Benefits.

Mail all signed copies of this enrollment form, PLUS:

1. A copy of your Medicare Card *(if available)*;
2. The Attestation Form.

Mail or Deliver to:

PrimeTime Health Plan
214 Dartmouth Ave SW, Suite 104
Canton, Ohio 44710-6119

Once we have processed your enrollment, we will mail you a copy of your completed enrollment form and your Evidence of Coverage Document. We will also include plan documents that will serve as your proof of insurance. These will allow you to receive covered health care services under your benefit plan until you receive your membership identification card, which will be arriving shortly thereafter.

If, at any time, you need help with this enrollment form, please call the PrimeTime Health Plan Service Center at 330-363-7407 or 1-800-577-5084. TTY users should call 330-363-7460 or 1-800-617-7446. Our Lobby is open Monday through Friday from 8:00 a.m. to 4:30 p.m., E.S.T. Our Call Center is open Monday through Friday from 8:00 a.m. to 8:00 p.m., E.S.T.

PrimeTime Health Plan is a Medicare Advantage Organization with a Medicare Contract.

H3664_CY13APP CMS Approved 08252012

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

Please check which plan you want to enroll in:

MA-PD HMO-POS Plans (H3664)
Your premium includes prescription drug coverage.

____Plus Plan (017): $69 per month

____Basic Select Plan (018): $43 per month

Medical Only HMO-POS Plan (H3664)
No prescription drug coverage.

____Basic MA Plan (014): $0 per month

Dental/Vision Optional Supplemental Benefit

Also enroll me in Dental/Vision coverage at an additional cost of $14.50 *per month.*

_____ Dental/Vision Optional Supplemental Benefit $14.50 per month.

You must continue to pay your Medicare Part B premium.

Last Name: ______________________ First Name: __________________ MI: ______ ❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date:(__ __ / __ __/ __ __ __ __) Sex: ❑ M ❑ F Home Phone: (_____) ___________________
M M / D D / Y Y Y Y

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

____

City: ______________________________ County ______________ State: _______ ZIP Code:____________

MAILING ADDRESS *(Only if different from your Permanent Residence Address):*

Street Address: ____

City: ____ State: _______ ZIP Code:______________

EMERGENCY CONTACT INFORMATION:

Name:________________________________ Phone: ____________________ Relationship To You: _________

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

Name of Primary Care Physician: ____

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

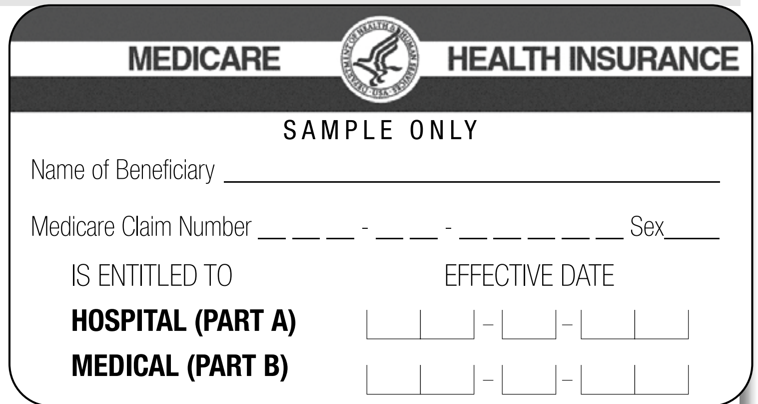
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

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


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name of Beneficiary ______________________________

Medicare Claim Number __ __ __ - __ __ - __ __ __ __ __ Sex____

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) [|]-[ ]-[|]

MEDICAL (PART B) [|]-[ ]-[|]

PAYING YOUR PLAN PREMIUM - *If you selected the BASIC MA Plan with $0 premium, please skip this section.*

You can pay your monthly plan premium *(including any late enrollment penalty that you currently have or may owe)* **by mail or by 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 the RRB. DO NOT pay PrimeTime Health Plan 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**
- ❑ **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:__ __ __ __ __ __ __ __ __ __ __

Account Type: ❑ *Checking*

- ❑ **Automatic deduction from your monthly Social Security or Railroad Retirment Board (RBB) 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.)*

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 other coverage: ______________________
   ID# for this coverage:_________________________________Group # for this coverage: __________________
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. Do you or your spouse work? ❑ Yes ❑ No
   If **"yes"**, is health care coverage provided for you? Yes ______ No ______
   If **"yes"**, will you continue to carry this coverage while on PrimeTime Health Plan? Yes ______ No ______
   If **"yes"**, does the employer have 20 or more employees? Yes ______ No ______
6. Are you the retiree? Yes ______ No ______
   If **"yes"**, when was your retirement date? (month/day/year) ________________
   If **"no"**, name of retiree:________________________________

If you need information in another language or in another 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 8:00a.m. to 8:00p.m., E.S.T. Our office hours are Monday through Friday from 8:00a.m. to 4:30p.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 BELOW

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 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 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 [**MA-PD plans**: 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.

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 Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): ______________

Broker ID# ______________ Date: __________ Eligibility Staff Use Only: SEP (type): __________