HealthPartners® MedicareRx Prescription Drug Coverage Emeriti® Retirement Health

2021 HEALTHPARTNERS® RETIREE NATIONAL CHOICE (PDP) WITH PART D ENROLLMENT FORM

Each individual must complete a separate enrollment form.

Generally, you are eligible to join HealthPartners® Retiree National Choice if:

- You are enrolled in the Federal Medicare Program for Part A (hospital coverage) AND Part B (medical coverage); and
- You live in the plan's service area. If you have questions about the service area and enrollment, please contact Medicare Sales at the numbers below. If you move to a different out-of-area address after the initial enrollment, CMS requires HealthPartners to disenroll you from the plan.

Important information:

- After we receive your enrollment form, we will send your member identification cards and a letter stating when your coverage begins. HealthPartners must receive your completed, signed and dated enrollment form by the last working day of the month before you want coverage to begin. Coverage always begins on the first day of a future month.
- Beneficiaries interested in assistance for prescription drug costs should contact Medicare Sales at the numbers below or contact Medicare at **800-MEDICARE**, 24 hours a day, 7 days a week. TTY **877-486-2048**.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to 75 percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. 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 **800-772-1213**. TTY users should call **800-325-0778**. You can also apply for Extra Help online at **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.
- This document is available in alternate formats and languages. Please contact Medicare Sales for more information.

To enroll, please follow these steps:

1) Fill out ALL of the form except for the boxes that say HealthPartners or Employer Use Only. Incomplete or incorrect forms may delay the effective date of your coverage. Use a ball-point pen and print firmly to ensure clear carbon copies.
2) Provide a PHOTOCOPY of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board with this enrollment form. Or you may fill out the information in Section Two exactly as it appears on your Medicare card.
3) Carefully read, sign and date the enrollment form.
4) Mail the completed form to HealthPartners in the enclosed postage-paid envelope.

Contact HealthPartners Medicare Sales

Call **952-883-7428** or **866-993-7428**.
TTY**: 711**

Return paper applications to:
Riverview Membership Accounting, MS 21103R
P.O. Box 9463
Minneapolis, MN 55440

Or fax them to **952-853-8746**.

Hours of Operation

From **Oct. 1 through Dec. 7,** we take calls from 8 a.m. to 6 p.m. CT, **Monday through Saturday.** From **Dec. 8 through Sept. 30,** call us 8 a.m. to 6 p.m. CT, **Monday through Friday** to speak with a representative. On Federal holidays and days we're closed, you can leave a message and we'll get back to you within one business day.

2021 HealthPartners® Retiree National Choice Enrollment Form

SECTION ONE: Personal Information

LAST NAME | FIRST NAME | M.I.

BIRTH DATE / / | SEX: ❑ F ❑ M | EMAIL ADDRESS* (optional)

TELEPHONE Home ( ) - | Is this a cell phone? ❑ YES ❑ NO

Alternate ( ) - | Is this a cell phone? ❑ YES ❑ NO

PERMANENT HOME ADDRESS (P.O. Box is not allowed) | APT #

CITY | STATE | ZIP | COUNTY

IN CARE OF NAME (If applicable)

IN CARE OF MAILING ADDRESS (If different from permanent home address) | APT #

CITY | STATE | ZIP | COUNTY

*By providing your email address, you agree that HealthPartners may send you emails.

SECTION TWO: Medicare 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)	_____

SECTION THREE: Requested Effective Date

HealthPartners must receive your completed, signed and dated enrollment form no later than the last working day of the month before you want coverage to begin. Coverage always begins the first day of a future month.

I am selecting the following plan option:

❑ Retiree National Choice Plan 1 – $263.60
❑ Retiree National Choice Plan 2 – $202.80
❑ Retiree National Choice Plan 3 – $166.40

I would like coverage to start: (Month) _____, 2021.

We will accommodate your requested effective date as best we can while still following Medicare guidelines.

NOTE: Applications can be received up to 90 days prior to or 120 days after your Medicare Part B effective date (or the first day of the month you turn 65). If you are past your Medicare Part B effective date and over age 65, your application cannot be received until 30 days prior to your requested effective date.

HealthPartners Use Only:

Eff. Date: _____ MR #: _____

Ctrct #: _____ Received: _____

SECTION FOUR: Please answer the following questions

Some individuals may have additional prescription drug coverage including other private insurance, TRICARE, federal employee health benefits, VA benefits, or state pharmaceutical assistance programs.

Your answers to the following questions will not affect your eligibility for enrollment in this plan:

❑ YES ❑ NO **1. Will you have other prescription drug coverage in addition to this Retiree National Choice plan?**

If YES, what is the name of the additional prescription drug coverage? _____

What is your ID number? _____

What is your group number? _____

2. What is the name of the Employer Group you will be enrolling in? _____

❑ YES ❑ NO Are you the retiree of the Employer Group?

If YES, what is/was your retirement date? _____

If NO, what is the name of the retiree whose coverage you're joining? _____

❑ YES ❑ NO **3. I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home or rehabilitation hospital).**

If YES, I moved/will move into/out of the facility on (MM/DD/YYYY) _____/_____/_____

Name of Institution: _____

Phone Number of Institution: _____

Address of Institution (number and street): _____

❑ YES ❑ NO **4. Are you currently a HealthPartners member?**

If YES, please give your identification number (to avoid duplication): _____

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that HealthPartners will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthPartners will release my information, including my prescription drug event data, to Medicare if applicable, 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 the 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 (Enrollee or authorized representative) **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 _____

Employer Use Only:

Group Name: _____ Group Number: _____ Site Number: _____ (if applicable)

SECTION FIVE: Authorization and Acknowledgement

PLEASE READ AND SIGN ON PAGE 3

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

HealthPartners® Retiree National Choice (The "Plan") is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore I will need to keep my Medicare Part A and Part B coverage. I will continue to pay my Medicare Part B premium. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time -- if I am currently in a Medicare Prescription Drug Plan, my enrollment in HealthPartners will end that enrollment. I know I may disenroll from this plan at any time by sending a signed written request to HealthPartners or by calling **800-Medicare**, available 24 hours a day, seven days a week. TTY users should call **877-486-2048**.

The Plan serves a specific service area. If I move out of the area that the Plan serves, I need to notify the Plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use HealthPartners network pharmacies. Once I am a member of the Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Plan's Evidence of Coverage document when I get it to know which rules I must follow to get coverage.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Plan, he/she may be paid based on my enrollment in the Plan.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

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. DO NOT pay the Plan the Part D-IRMAA.

8170 33rd Ave. S.
PO Box 1309
Minneapolis, MN 55440-1309