ASPIREHEALTHPLAN

You can enroll today

STEP ONE: Enrollment eligibility

You are eligible to enroll in Aspire Health Value, Aspire Health Advantage, or Aspire Health Plus if:

- You are entitled to Medicare Part A (hospital insurance) and enrolled in Part B (medical insurance)
- You reside in Aspire Health Plan service area
- You **do not** have end-stage renal disease (ESRD) or kidney failure requiring an ongoing dialysis program; or, If you have had ESRD and needed dialysis, but you had a successful kidney transplant within the last 36 months and no longer require dialysis (documentation from your physician is required)

Typically, you may enroll in a Medicare Advantage Prescription Drug (MAPD) plan only during the Annual Election Period (AEP) from October 15 through December 7 each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please contact us at the numbers listed below if you have questions.

STEP TWO: Read materials carefully

Review the enclosed materials to understand the Aspire Health Value, Aspire Health Advantage and Aspire Health Plus plans. If you have any questions, please contact us at the numbers listed.

STEP THREE: Complete the enrollment form

For best results: Place a piece of cardboard behind the yellow copy, press hard enough to go through 2 copies, write neatly, and use a blue or black ballpoint pen.

- **Each individual applicant must fill out a separate enrollment form**
- Have your red, white, and blue Medicare card ready. You will be asked to fill in the information about your Medicare benefits EXACTLY as they appear on your Medicare card
- **Select your Primary Care Physician (PCP).** Be sure to fill in the physician's name and location as it appears in the Aspire Health Plan Provider/Pharmacy Directory.
- Read the questions and fill in the answers
- Read the "Important Information" section
- **Sign and date the form.** Your enrollment is not complete without a signature. Please review to make sure all sections are filled out completely

- **Mail the top copy of each form in the postage-paid envelope provided.**
  Or mail to: Aspire Health Plan, P.O. Box 5490, Salem, OR 97304

If you have not yet received your Medicare card, you can attach a copy of your "Letter of Verification" from the Social Security Administration or Railroad Retirement Board.

We can help

If you'd like assistance, please call us toll-free (888) 864-4611 (TTY: 711). We are open 8 a.m.—8 p.m. PT Monday through Friday from April 1 through September 30 (except for certain holidays) and 8 a.m.—8 p.m. PT 7 days a week from October 1 through March 31.

Thank you for choosing Aspire Health Plan.

ASPIREHEALTHPLAN

2019 Medicare Advantage Prescription Drug (MA-PD) Individual Enrollment Request Form

Please contact Aspire Health Plan if you need information in another language or format (large print).

Typically, you may enroll in a Medicare Advantage Prescription Drug (MAPD) plan only during the Annual Election Period (AEP) from October 15 through December 7. There are exceptions called Special Election Periods (SEP) 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 indicating, to the best of your understanding, 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've had Medicare prior to now and am now turning 65.

☐ I'm in the annual election period (October 15 - December 7 each year).

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

☐ 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: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I recently was released from incarceration. I was released on: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I recently obtained lawful presence status in the United States. I got this status on: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level ofMedicaid assistance, or lost Medicaid) on: _____/_____/__________ (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 : _____/_____/__________ (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). I moved/will move into/out of the facility on: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I recently left a PACE program on: _____/_____/__________ (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: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I am leaving employer or union coverage on: _____/_____/__________ (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 started on: _____/_____/__________ (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 from the SNP on: _____/_____/__________ (M M / D D/ Y Y Y Y)

☐ I was affected by a weather-related emergency or major disaster (as declared by them 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.

☐ Other (please explain):

____

If none of these statements apply to you or you're not sure, please call Aspire Health Plan toll free (855) 570-1600 TTY users should call 711 to see if you are eligible to enroll. Our hours are: 8 a.m.–8 p.m. Monday through Friday (except certain holidays) from April 1 to September 30 and 8 a.m.–8 p.m. seven days a week October 1 to March 31.

PLEASE RETURN TO ASPIRE HEALTH PLAN

To enroll in Aspire Health Plan, please provide the following information:

Please check which plan you want to enroll in:
☐ **Aspire Health Value (HMO)** ($34.80)
☐ with Enhanced Benefits — Option A = $44.90 + $34.80 = $79.70/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $34.80 = $84.70/mo.

☐ **Aspire Health Advantage (HMO)** ($129/mo.)
☐ with Enhanced Benefits — Option A = $44.90 + $129 = $173.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $129 = $178.90/mo.

☐ **Aspire Health Plus (HMO-POS)** ($249/mo.)
☐ with Enhanced Benefits — Option A = $44.90 + $249 = $293.90/mo.
☐ with Enhanced Benefits — Option B = $49.90 + $249 = $298.90/mo.
Note: At time of enrollment the Late Enrollment Penalty (LEP) may not be known; if an LEP is confirmed by CMS, the cost per month may change.

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: ____/____/________ (M M / D D/ Y Y Y Y)	Sex: ☐ M ☐ F	Home phone: (___) - ______ - ________	Alternative phone: (___) - ______ - ________

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

City:	State:	ZIP:

Mailing address (only if different from your permanent residence address): ☐ Same as permanent

City:	State:	ZIP:

Emergency contact:	Phone: (___) - ______ - ________	Relationship to you:

E-mail address (optional):

Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section. Fill in the information below as it appears on your 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): ______________________

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

PLEASE RETURN TO ASPIRE HEALTH PLAN

Paying your plan premium

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.

If you are assessed a Part D-Income-Related Monthly Adjustment Amount (IRMAA), 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 Aspire Health Plan for 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 75% or more of 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 (800) 772-1213. TTY users should call (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 receive a bill each month.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account holder name: ________________________________

Bank routing number: ______________________________

Bank name: ____ Account type: ☐ Checking ☐ Savings

Bank account number: _______________________________

☐ Automatic deduction from your monthly Social Security or Railroad Retirement board (RRB) benefits check. I get monthly benefits from: ☐ Social Security ☐ RRB

(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 RETURN TO ASPIRE HEALTH PLAN

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 addition 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 Aspire 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 #:	Group #:

3. **Are you a resident in a long-term care facility, such as a nursing home?** ☐ Yes ☐ No
   If "yes" please provide the following information: Name of institution: ____________________
   Address:____________________
   City____________________ State__________ ZIP: __________
   Phone #: (______) ________- __________

4. **Are you enrolled in your State Medicaid program?** ☐ Yes ☐ No
   If yes, please provide your Medicaid number: ____________________

5. **Do you work?** ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

6. **Please choose the name of a Primary Care Physician (PCP) from our list of network physicians, which can be obtained from your agent, on our website at www.aspirehealthplan.org, or by calling our customer service department.** Our hours of operation are from 8 a.m. – 8 p.m., Monday through Friday (except certain holidays) from April 1 to September 30, and 8 a.m. – 8 p.m., seven days a week October 1 to March 31.
   Physician name (First and Last): ____________________
   City:__________ ZIP: __________ Are you currently a patient of this provider? ☐ Yes ☐ No
   NOTE: If you do not choose one of the PCPs from our list, the plan will automatically choose one for you. Please indicate a gender preference for the plan-selected physician. ☐ Male ☐ Female

7. **Please check one of the boxes if you prefer we send you information in a language other than English or in an accessible format.** ☐ Spanish ☐ Large print
   Please contact Aspire Health Plan toll-free (855) 570-1600 if you need information in an accessible format or language other than what is listed above. Our hours are: 8 a.m. – 8 p.m., Monday through Friday (except certain holidays) from April 1 to September 30, and 8 a.m. – 8 p.m., seven days a week October 1 to March 31.
   TTY users should call 711.

Please read this important information:
If you currently have health coverage from an employer or union, joining Aspire Health Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aspire 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 about who to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE RETURN TO ASPIRE HEALTH PLAN

Please read and sign below:

By completing this enrollment application, I agree to the following:
Aspire Health Plan is a Medicare Advantage Prescription Drug plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A and B. I can only be in 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. 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 each year), or under certain special circumstances.

Aspire Health Plan serves a specific service area. If I move out of the area that Aspire 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 Aspire 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 Aspire Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage Prescription Drug 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 Aspire Health Plan coverage begins, I must get all of my healthcare from Aspire Health Plan except for emergency or urgently needed services, or out-of-area dialysis services. Services authorized by Aspire Health Plan and other services contained in my Aspire Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR ASPIRE 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 Aspire Health Plan he/she may be paid based on my enrollment in Aspire Health Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that Aspire Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Aspire Health Plan 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. 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 Aspire Health Plan or Medicare.

Your signature:	Today's date: ______/_______/_________ (MM / DD / YYYY)

If you are legally authorized to represent the enrollee, you must sign and date above and provide the following information:

Name and address:	Phone: (____) - _____ - ______	Relationship to enrollee:

Thank you. You have completed the individual enrollment request form.

PLEASE RETURN TO ASPIRE HEALTH PLAN

FOR AGENT USE ONLY

Name of Agent/Broker (if assisted in enrollment):	Agent signature:

Proposed effective date of coverage: ______/_______/_________
(MM / DD / YYYY)

Agent ID:

FOR INTERNAL OFFICE USE ONLY

Initial receipt date: ______/_______/_________
(MM / DD / YYYY)

PBP #:

Election period: ☐ ICEP/IEP ☐ AEP ☐ SEP (type): ________________________
☐ Not eligible

Aspire Health Plan is a Medicare Advantage HMO plan sponsor with a Medicare contract. Enrollment in the Plan depends on contract renewal. Aspire 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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (TTY: 711). 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 1-855-570-1600 (TTY 711). This information is not a complete description of benefits.

Call 1-855-570-1600 (TTY: 711) for more information. We are open 8 a.m.–8 p.m. PT Monday through Friday from April 1 through September 30 (except certain holidays) and 8 a.m.–8 p.m. PT seven days a week from October 1 through March 31. Medicare beneficiaries may also enroll in Aspire Health Plan through the CMS Medicare Online Enrollment Center located at http://www.medicare.gov.

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PLEASE RETURN TO ASPIRE HEALTH PLAN