“I’m ready to enroll. What do I do now?”

We’re here to support you. Inside you’ll find enrollment forms, along with a handy checklist to help you get started.

You can also save time by enrolling on our website or over the phone. It’s fast. It’s easy. Check it out today and start your journey forward.

Effective January 1, 2019 to December 31, 2019

fallonhealth

Everything you need to enroll today!

Thank you for applying for membership with Fallon Senior Plan™ Medicare Advantage.

When filling out the enrollment form please remember:

- Complete the entire enrollment form and be sure to **sign it**. (If we receive an incomplete form, it may not be processed and may be returned to you for additional information.)
- Press firmly with your pen when filling out the form.

Use this checklist to make sure you have filled out the following information on the enrollment form:

__ Your plan choice
__ Your full legal name as it appears on your Medicare card
__ Your date of birth
__ Your gender
__ Your telephone number
__ Your home address
__ Your mailing address (if different from your home address)
__ Your Medicare information (In order for your enrollment to be complete, you must either copy information from your Medicare card onto the enrollment form or you may attach a photocopy of your Medicare card or a copy of your Letter of Verification from the Social Security Administration or Railroad Retirement Board. If you do not have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security office to enroll or obtain proof of enrollment.)
__ Answers to the important questions on page two of the enrollment form
__ Your plan premium payment option
__ If you required assistance in completing this enrollment form, please include the assisting individual's signature, his or her relationship to you, his or her address, and his or her phone number.

Remember these three steps:

1. Sign and date the enrollment form after reading the back.
2. Pull out the pink copy of your signed and dated enrollment form for your records.
3. Return the rest of the form in the enclosed return envelope. If you misplaced the return envelope, mail your enrollment form to:

   Fallon Health
   Attn: Medicare Sales
   10 Chestnut St.
   Worcester, MA 01608-9971

   Or, you may fax it to us at 1-508-757-0572.

If you need further information to complete this enrollment form, please call us at 1-888-377-1980 (TRS 711).

You can also enroll online at fallonhealth.org/seniorplan or over the phone at 1-888-377-1980 (TRS 711).

Once we have received your completed enrollment form, a member of our Medicare team may call you to make sure you understand how our plan works, and to answer any questions you may have.

fallonhealth

Ready to enroll NOW?

Call us, or visit our website—when it's convenient for you.

fallonhealth.org/seniorplan
1-888-377-1980 (TRS 711)
8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week.)

Fallon Health is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.

H9001_F_2018_30 Accepted 08262017
17-686-101 Rev. 01 8/18

Fallon Senior Plan™ Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-377-1980 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week).

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage (EOC),* especially for those services that you routinely see a doctor. Visit fallonhealth.org/seniorplan or call 1-888-377-1980 (TRS 711) to view a copy of the *EOC*.

- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2020.

- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

- ☐ Our HMO-POS plans allow you to see providers outside of our network (non-contracted providers). However, while we pay for covered services provided by a non-contacted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

fallon health

Fallon Health is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.

2019 Fallon Senior Plan™
Individual Enrollment Request Form

fallonhealth

Please contact Fallon Health if you need information in another language or format (Braille).

To enroll in Fallon Senior Plan (FSP), please provide the following information.
Please check ☑ which plan you want to enroll in:

Fallon Senior Plan options	If you live in one of the following counties:					
	Worcester, Franklin	Hampden, Hampshire	Essex, Suffolk, Plymouth	Middlesex, Norfolk, Bristol	Barnstable	Berkshire
FSP Flex Enhanced Rx HMO	❑ $0 month (034-06)	❑ $0 month (034-05)	❑ $0 month (034-08)	❑ $0 month (034-09)	—	—
FSP Super Saver Rx HMO	❑ $22 month (032-06)	❑ $16 month (032-05)	❑ $22 month (032-08)	❑ $22 month (032-09)	❑ $28 month (032-04)	❑ $22 month (032-07)
FSP Saver HMO	❑ $93 month (029-06)	❑ $8 month (029-05)	❑ $44 month (029-08)	❑ $44 month (029-09)	❑ $91 month (029-04)	❑ $59 month (029-07)
FSP Saver Enhanced Rx HMO	—	❑ $50 month (030-05)	❑ $72 month (030-08)	❑ $72 month (030-09)	❑ $112 month (030-04)	❑ $93 month (030-07)
FSP Saver Enhanced Rx HMO-POS	❑ $103 month (013)	—	—	—	—	—
FSP Standard Enhanced Rx HMO	❑ $218 month (015)	—	—	—	—	—
FSP Plus Enhanced Rx HMO	❑ $275 month (031-06)	—	❑ $173 month (031-08)	❑ $173 month (031-09)	❑ $227 month (031-04)	❑ $206 month (031-07)
FSP Plus Enhanced Rx HMO-POS	—	❑ $126 month (033)	—	—	—	—

Last name		❑ Mr. ❑ Mrs. ❑ Ms.
First name	Middle initial	
Birth date __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)	Sex ❑ M ❑ F	
Home phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Alternate phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	
Permanent residence street address (P.O. Box not allowed)		
City/town	State	ZIP
Mailing address (if different from above)		
City/town	State	ZIP
Email address (optional)		

White and yellow copies - Fallon Health **Pink copy** - Member

Please provide your Medicare insurance 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 the Social Security Administration or the Railroad Retirement Board.

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

Name (as it appears on your Medicare card):

_____

Medicare number: _____

Is entitled to:

❑ Hospital (Part A) Effective date: _____

❑ Medical (Part B) _____

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 Fallon Senior 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 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: _____

   Phone number: _____

   Address (number and street): _____

4. **Are you enrolled in the Massachusetts Medicaid (MassHealth) program?** ❑ Yes ❑ No
   If "yes", please provide your Medicaid (MassHealth) number: _____

5. **Do you or your spouse work?** ❑ Yes ❑ No

6. **Name of chosen primary care provider** (PCP): _____
   Please make sure your chosen PCP is in our network. If you are an existing patient, check here. ❑

7. **What is the name of your previous insurance carrier? (optional):**

   _____

Please check the box below if you would prefer us to send you information in another accessible format:

❑ Braille ❑ Audio tape ❑ Large print

Please contact Fallon Health if you need information in an accessible format or language other than what is listed above. Please contact us at 1-888-377-1980 (TRS 711), 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

Paying your plan premium:

If you enroll in one of our plans with Medicare prescription drug coverage that does not have a monthly premium, and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will need to know how you would prefer to pay it. Please select a payment option from below to pay a late enrollment penalty.

If you enroll in a plan with Medicare prescription drug coverage that has a monthly premium and we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), you will pay this through the payment option you select below because it will be included with your monthly premium.

For more information on premiums and prescription drug costs based on your income, please see the back of this form.

If you don't select one of the following payment options, we will bill you monthly. Please select a premium payment option:

- ❑ Get a bill monthly.
- ❑ Automated clearinghouse (ACH) transfer from your checking or savings account each month. If you choose this option, we will contact you for more information.
- ❑ Credit card (Discover, MasterCard or VISA only.) If you choose this option, we will contact you for more information.
- ❑ Automatic deduction from your monthly Social Security or 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.

  I get monthly benefits from: ❑ Social Security ❑ RRB

STOP Please read this important information. STOP

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

Typically, you may enroll in a Medicare Advantage plan during the annual election period between October 15 and 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 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 was released from incarceration. I was released 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 obtained lawful presence status in the United States. I got this status 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 the facility on (insert date): _____
- ❑ I recently left a PACE program on (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 am leaving employer or union 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 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.
- ❑ None of these statements apply to me.*

* Please contact Fallon Health at 1-888-377-1980 (TRS 711) to see if you are eligible to enroll. We are open 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.)

Please read the important information on the back and sign below.

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.

_____ _____

Your signature/authorized representative Date

If you are the authorized representative, you must provide the following information:

Name (print): _____

Address: _____

Phone number: _____

Relationship to enrollee: _____

BROKER/AGENT INFO: Prior insurance: _____

Requested effective date: _____ Election type: _____

Agency name (if applicable): _____

Broker/agent name: _____ Mass. Lic#: _____

SOA form received: ❑ Yes ❑ No If no, why: _____

FALLON USE ONLY: RTS verification: ❑ Yes ❑ No QNXT attribute needed: ❑ Yes ❑ No

Date received: _____ Method of receipt: _____

Telephonic: ❑ No ❑ Yes If yes, confirmation number: _____

❑ ICEP/IEP: _____ ❑ AEP: _____ ❑ SEP (type): _____ ❑ Not eligible: _____

Sales staff initials: _____ Plan ID#: _____ Effective date of coverage: _____

ENROLLMENT DEPT USE ONLY:

Please read the important information below.

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

Fallon Health is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) 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 Advantage Plan or Medicare Prescription Drug Plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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.

Fallon Senior Plan serves a specific service area. If I move out of the area that Fallon Senior 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 Fallon Senior 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 Fallon Senior 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 Fallon Senior Plan coverage begins, I must get all of my health care from Fallon Senior Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Senior Plan and other services contained in my Fallon Senior Plan *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON SENIOR 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 Fallon Health, he or she may be paid based on my enrollment in Fallon Senior Plan.

Release of information: By joining this Medicare health plan, I acknowledge that Fallon Senior Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Senior Plan will release my information, including my prescription drug event data (if applicable) 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.

Information on premiums and prescription drug costs based on your income:

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 coinsurance. 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 enroll in a plan with Medicare prescription drug coverage, and 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, you will be responsible for the amount that Medicare doesn't cover.

If you enroll in a plan with Medicare prescription drug coverage and 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 Fallon Health the Part D-IRMAA.