# 2022 Summary of Benefits

Jan. 1, 2022 – Dec. 31, 2022

888-645-6025 | TTY 711

Seven Days a Week, 8 A.M. to 8 P.M.
*(October 1 to March 31)*

Monday - Friday, 8 A.M. to 8 P.M.
*(All Other Times)*

**BlueCross RX** PLUS℠(PDP)
**BlueCross RX** VALUE℠(PDP)
**BlueCross RX** ESSENTIAL℠(PDP)

# 2022 Summary of Benefits
## BlueCross Rx Essential (PDP), BlueCross Rx Value (PDP) and BlueCross Rx Plus (PDP)
January 1, 2022 – December 31, 2022

This booklet gives you a summary of what we cover and what you pay. The information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and copayments/coinsurance may change on January 1 of each year. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage.*

**You have choices about how to get your Medicare prescription drug benefits**

- One choice is to get your prescription drug coverage through a Medicare Prescription Drug Plan, like Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP).
- Another choice is to get your prescription drug coverage through a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan that offers Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.

**Tips for comparing your Medicare choices**

This Summary of Benefits booklet gives you a summary of what **Rx Essential (PDP)**, **Rx Value (PDP)** and **Rx Plus (PDP)** cover and what you pay.

- If you want to compare our plans with other Medicare drug plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *2022 Medicare & You* handbook. View it online at www.medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Sections in this booklet**

- Things to Know About Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits

This document is available in other formats, such as Braille, large print or audio.

This document may be available in a non-English language. For additional information, call us at 1-800-930-2836. TTY users call 711.

**THINGS TO KNOW ABOUT RX ESSENTIAL (PDP), RX VALUE (PDP) AND RX PLUS (PDP)**

**Hours of Operation**

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Eastern time.
- All other times, you can call us Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

**Rx Essential (PDP), Rx Value (PDP) and Rx Plus (PDP) Phone Numbers and Website**

- If you are a member of one of these plans, call toll-free 1-888-645-6025. TTY users call 711.
- If you are not a member of this plan, call toll-free 1-800-930-2836. TTY users call 711. (Calls to this number are answered by a licensed insurance agent.)
- Our website: www.SCBluesMedAdvantage.com/marx22

**Who can join?**

To join **Rx Essential (PDP)**, **Rx Value (PDP)** or **Rx Plus (PDP)**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, and live in our service area. Our service area includes the following: South Carolina.

**Which drugs are covered?**

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (www.SCBluesMedAdvantage.com/marx22). Or, call us and we will send you a copy of the formulary.

**How will I determine my drug costs?**

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate the tier your drug is in to determine how much it will cost. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur (after you meet your deductible – Rx Essential (PDP) and Rx Value (PDP) only): Initial Coverage, Coverage Gap and Catastrophic Coverage.

**Which pharmacies can I use?**

We have a network of pharmacies. You must generally use these pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our *Pharmacy Directory* at our website (www.SCBluesMedAdvantage.com/marx22). Or, call us and we will send you a copy of the directory.

# Summary of Benefits

January 1, 2022 – December 31, 2022

## MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| Premium and Deductible Details | Rx Essential (PDP) | Rx Value (PDP) | Rx Plus (PDP) |
|---|---|---|---|
| **How much is the monthly premium?** | $26.10 per month. You must continue to pay your Medicare Part B premium. | $115.90 per month. You must continue to pay your Medicare Part B premium. | $207.20 per month. You must continue to pay your Medicare Part B premium. |
| **How much is the deductible?** | $480 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible. | $400 per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible. | $0. This plan does not have a deductible. |

## PRESCRIPITON DRUG BENEFITS

The following section includes information about what we cover and what you pay during the four "drug payment stages" of our plan's benefits. The stages are Yearly Deductible (Rx Essential (PDP) and Rx Value (PDP) only), Initial Coverage, Coverage Gap and Catastrophic Coverage. Your cost-sharing may change as you enter another stage of the Part D benefit. For more details, call us (the number is on the cover of this booklet) or see your *Evidence of Coverage.* The *Evidence of Coverage* is available on our website.

| Initial Coverage | Rx Essential (PDP) | Rx Value (PDP) | Rx Plus (PDP) |
|---|---|---|---|
| **What You Pay** | After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>You may get your drugs at network retail pharmacies and mail-order pharmacies. | After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>You may get your drugs at network retail pharmacies and mail-order pharmacies. | You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>You may get your drugs at network retail pharmacies and mail-order pharmacies. |

How much you pay for your prescription will depend in part on which cost-sharing tier your drug is in.

| Tier Number | Tier Label | General Description |
|---|---|---|
| Tier 1 | Preferred Generic | The lowest tier and includes preferred generic drugs. |
| Tier 2 | Generic | Includes generic drugs |
| Tier 3 | Preferred Brand | Includes preferred brand drugs and non-preferred generic drugs. |
| Tier 4 | Non-Preferred Drug | Includes non-preferred brand drugs and non-preferred generic drugs. |
| Tier 5 | Specialty Tier | The highest tier. It contains very high-cost brand and generic drugs that may require special handling and/or monitoring. |

Your costs will also differ relative to the pharmacy's status as preferred or standard retail, mail-order, Long-Term Care (LTC), or Home Infusion, and whether you receive a one-month (30-day), two-month (60-day), or three-month (90-day) supply.

**Standard Retail Cost-Sharing**

| Tier | Rx Essential (PDP) | | | Rx Value (PDP) | | | Rx Plus (PDP) | | |
|---|---|---|---|---|---|---|---|---|---|
| Each plan has 5 cost-sharing tiers | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | $15 copay | $30 copay | $45 copay | $10 copay | $20 copay | $30 copay | $5 copay | $10 copay | $15 copay |
| Tier 2 (Generic) | $20 copay | $40 copay | $60 copay | $20 copay | $40 copay | $60 copay | $8 copay | $16 copay | $24 copay |
| Tier 3 (Preferred Brand) | $47 copay | $94 copay | $141 copay | $47 copay | $94 copay | $141 copay | $27 copay | $54 copay | $81 copay |
| Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 45% of the cost | 45% of the cost | 45% of the cost |
| Tier 5 (Specialty Tier) | 25% of the cost | 25% of the cost | 25% of the cost | 26% of the cost | 26% of the cost | 26% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |

**Preferred Retail Cost-Sharing**

| Tier | Rx Essential (PDP) | | | Rx Value (PDP) | | | Rx Plus (PDP) | | |
|---|---|---|---|---|---|---|---|---|---|
| Each plan has 5 cost-sharing tiers | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay | $5 copay | $10 copay | $15 copay | $0 copay | $0 copay | $0 copay |
| Tier 2 (Generic) | $5 copay | $10 copay | $15 copay | $15 copay | $30 copay | $45 copay | $3 copay | $6 copay | $9 copay |
| Tier 3 (Preferred Brand) | $40 copay | $80 copay | $120 copay | $40 copay | $80 copay | $120 copay | $20 copay | $40 copay | $60 copay |
| Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost | 50% of the cost | 45% of the cost | 45% of the cost | 45% of the cost | 40% of the cost | 40% of the cost | 40% of the cost |
| Tier 5 (Specialty Tier) | 25% of the cost | 25% of the cost | 25% of the cost | 26% of the cost | 26% of the cost | 26% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |

**Standard Mail-Order Cost-Sharing**

| Tier | Rx Essential (PDP) | | | Rx Value (PDP) | | | Rx Plus (PDP) | | |
|---|---|---|---|---|---|---|---|---|---|
| Each plan has 5 cost-sharing tiers | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | $15 copay | $30 copay | $37.50 copay | $10 copay | $20 copay | $25 copay | $5 copay | $10 copay | $12.50 copay |
| Tier 2 (Generic) | $20 copay | $40 copay | $50 copay | $20 copay | $40 copay | $50 copay | $8 copay | $16 copay | $20 copay |
| Tier 3 (Preferred Brand) | $47 copay | $94 copay | $141 copay | $47 copay | $94 copay | $117.50 copay | $27 copay | $54 copay | $67.50 copay |
| Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 50% of the cost | 45% of the cost | 45% of the cost | 45% of the cost |
| Tier 5 (Specialty Tier) | 25% of the cost | 25% of the cost | 25% of the cost | 26% of the cost | 26% of the cost | 26% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |

**Preferred Mail-Order Cost-Sharing**

| Tier | Rx Essential (PDP) | | | Rx Value (PDP) | | | Rx Plus (PDP) | | |
|---|---|---|---|---|---|---|---|---|---|
| Each plan has 5 cost-sharing tiers | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay | $5 copay | $10 copay | $12.50 copay | $0 copay | $0 copay | $0 copay |
| Tier 2 (Generic) | $5 copay | $10 copay | $12.50 copay | $15 copay | $30 copay | $37.50 copay | $3 copay | $6 copay | $7.50 copay |
| Tier 3 (Preferred Brand) | $40 copay | $80 copay | $100 copay | $40 copay | $80 copay | $100 copay | $20 copay | $40 copay | $50 copay |
| Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost | 50% of the cost | 45% of the cost | 45% of the cost | 45% of the cost | 40% of the cost | 40% of the cost | 40% of the cost |
| Tier 5 (Specialty Tier) | 25% of the cost | 25% of the cost | 25% of the cost | 26% of the cost | 26% of the cost | 26% of the cost | 33% of the cost | 33% of the cost | 33% of the cost |

| Plan | Rx Essential (PDP) and Rx Value (PDP) | Rx Plus (PDP) |
|---|---|---|
| **Long-Term Care, Out-of-Network and other Limitations** | If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br><br>You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged.<br><br>Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy. | If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br><br>You may get drugs from an out-of-network pharmacy in situations where you are not able to use a network pharmacy, but you may pay more than you pay at an in-network pharmacy. For more information on when your drugs can be covered at an out-of-network pharmacy, call us or see your *Evidence of Coverage*. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged.<br><br>Some drugs have limitations. The limitations are quantity limits, prior authorization, and step therapy. |
| **Plan** | **Rx Essential (PDP) and Rx Value (PDP)** | **Rx Plus (PDP)** |
| **Coverage Gap** | Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.<br><br>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap. | Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there is a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.<br><br>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.<br><br>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. |

**Coverage Gap Standard Retail Cost-Sharing**

| Tier | Rx Essential (PDP) and Rx Value (PDP) | | | | Rx Plus (PDP) | | | |
|---|---|---|---|---|---|---|---|---|
| | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 1 (Preferred Generic) | $5 copay | $10 copay | $15 copay |
| Tier 2 (Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 2 (Generic) | $8 copay | $16 copay | $24 copay |

**Coverage Gap Preferred Retail Cost-Sharing**

| Tier | Rx Essential (PDP) and Rx Value (PDP) | | | | Rx Plus (PDP) | | | |
|---|---|---|---|---|---|---|---|---|
| | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay |
| Tier 2 (Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 2 (Generic) | $3 copay | $6 copay | $9 copay |

**Coverage Gap Standard Mail-Order Cost-Sharing**

| Tier | Rx Essential (PDP) and Rx Value (PDP) | | | | Rx Plus (PDP) | | | |
|---|---|---|---|---|---|---|---|---|
| | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 1 (Preferred Generic) | $5 copay | $10 copay | $15 copay |
| Tier 2 (Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 2 (Generic) | $8 copay | $16 copay | $20 copay |

**Coverage Gap Preferred Mail-Order Cost-Sharing**

| Tier | Rx Essential (PDP) and Rx Value (PDP) | | | | Rx Plus (PDP) | | | |
|---|---|---|---|---|---|---|---|---|
| | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** | **Covered Drugs** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| Tier 1 (Preferred Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay |
| Tier 2 (Generic) | No Coverage | No Coverage | No Coverage | No Coverage | Tier 2 (Generic) | $3 copay | $6 copay | $7.50 copay |

**Catastrophic Coverage:**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of:

- 5% of the cost, or
- $3.95 copay for generic (including brand drugs treated as generic) and $9.85 copay for all other drugs.

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

BlueCross BlueShield of South Carolina is a Medicare Advantage PDP organization with a Medicare contract. Enrollment in BlueCross BlueShield of South Carolina depends on contract renewal.

OMB No. 0938-1378
Expires:7/31/2023

South Carolina
Medicare Advantage

# 2022 BlueCross Rx Essential[SM]/Rx Value[SM]/Rx Plus[SM] (PDP) Individual Enrollment Request Form

## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

## When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

## What do I need to complete this form?

- Your Medicare Number (the number on your red, white,and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

## Reminders:

- If you want to join a plan during fall open enrollment (October 15 - December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account, credit/debit card or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:
BlueCross Rx
P.O Box 100191
Columbia, SC 29202

Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call BlueCross Rx at 1-888-645-6025. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a BlueCross Rx al 1-888-645-4227/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

## Section 1 – All fields on this page are required (unless marked optional)

**Select the plan you want to join:**

_______ BlueCross Rx Essential - $26.10 per month
_______ BlueCross Rx Value - $115.90 per month
_______ BlueCross Rx Plus - $207.20 per month

FIRST name:______________________________

LAST name:_______________________________ (Optional) Middle Initial:_______

Birth date: (MM/DD/YYYY) (____/____/____) Sex:____Male____Female

Phone number: (____)________- __ ____ _

Permanent Residence street address
(Don't enter a PO Box):____________________________________________________________

City:___________________________ State:_____ ZIP Code:_________________

Mailing address, if different from your permanent address (PO Box allowed):

Street address:_________________________________________________________________

City:___________________________ State:_____ ZIP Code:_________________

Emergency Contact: ___________________________________________

Phone Number: (____)_______- __ _______ __ Relationship to You: __________________

E-mail Address: (optional)

_____________________________________________________________________________

## Your 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 (MM/DD/YYYY):

**HOSPITAL (Part A)** ________/__________/__________
**MEDICAL (Part B)** ________/__________/__________

You must have Medicare Part A and Part B to join a Medicare Prescription Drug Plan.

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueCross Rx?

_____ Yes _____ No

Name of other coverage: ________________________

Member number for this coverage: ________________________

Group number for this coverage: ________________________

**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BlueCross Rx.
- By joining this Medicare Prescription Drug Plan, I acknowledge that BlueCross Rx will share my informationwith Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

**Signature:**______________________________________ **Today's date:**_________________

**If you're the authorized representative, sign above and fill out these fields:**

Name: ______________________________________________

Address: ______________________________________________

______________________________________________

Phone number: (_____)________-___________Relationship to enrollee: ________________________

**Agent Use Only:**

Plan ID#: ____________________________

Effective Date of Coverage: ______________________

ICEP/IEP:___________AEP:_____________SEP (type): ___________________

BlueCross BlueShield of SC MAPD Agent ID: ___________________________

Agent Name: ______________________________________________________

Date: ______________________

**Agents must submit a signed enrollment form within 24 hours of receipt.**

**Section 2 – All fields on this page are optional**

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Select one if you want us to send you information in a language other than English.

Spanish______ Other ____

Select one if you want us to send you information in an accessible format.

___ Braille ___ Large Print ___ Audio CD

Please contact BlueCross at 1-888-645-6025 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

Do you work?____Yes_____No Does your spouse work? ___Yes ___No

List your Primary Care Physician (PCP), clinic, or health center:

________________________________________________________________________________

I want to get the following materials via email. Select one or more.

___ Evidence of Coverage ___ Pharmacy Directories ___ Formulary

**Paying your plan premiums**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay BlueCross the Part D-IRMAA.

Please select a premium payment option:

☐ Get a bill.

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

Account holder name:______________________________________________________

Bank routing number: __ __ ____ ____ ____ _

Bank account number: __ __ ____ ____ ____ __ __ __ __ __ ____ ____ _

☐ Credit Card. Please provide the following information:

Type of Card: ___________________________

Name of Account holder as it appears on card: ____________________________________

Account number: __ ____ __ ____ ____ ______ __ ____ ____ _

Expiration Date (MM/YYYY):_____/ ________ _

Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit 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.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

OMB No. 0938-1378
Expires:7/31/2023

## Attestation of Eligibility for an Enrollment Period

**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.

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 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 applies to you or you're not sure, please contact BlueCross at 1-888-645-6025, TTY users should call 711. Our office hours are 8 a.m. to 8 p.m., Eastern Time, Monday - Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1, through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

# Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

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Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

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Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

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Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

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Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

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あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارهٔ این برنامهٔ بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارهٔ 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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*BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association*