MINNESOTA RESIDENTS

Medica Prime Solution® (Cost) Plan with Part D

2024 Change Form — Standard, Basic, Thrift or Enhanced

A	PLEASE READ BEFORE COMPLETING YOUR APPLICATION

Use this form if you want to change your Medica Prime Solution medical plan with Part D coverage. You typically can only change your Part D selection during AEP or Special Enrollment Period (SEP). **This form cannot be used to enroll in Medica Prime Solution for the first time**.

If you have questions concerning your application or need information in another language or format (like Braille or large print), please contact Medica from 8 a.m.-8 p.m. CT, 7 days a week at 1 (800) 918-2143 (TTY: 711).

Return completed applications one of three ways:

Mail	Fax	Securely Upload
Medica PO Box 740110 Atlanta, GA 30374-0110	1 (855) 250-2166	Medica.com/EnrollmentUpload

Medica®

1	PERSONAL INFORMATION		
	Legal First Name	Middle Initial	Last Name
	Gender ❍ Male ❍ Female		Birthdate __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)
	Primary Telephone (*With area code)* (____) ____ - _____		Medica Member Number *(required)*

Permanent Residence Address				
Street	City	State	Zip Code	County
Mailing Address *(If different than Permanent Resident Address)*				
Street	City	State	Zip Code	County

Email Address
Optional – By providing your email, you agree Medica may send you communications about your plan.

2	EFFECTIVE DATE AND PLAN SELECTION
	I request an effective date for the first day of __ __ , 20__ __. M M Y Y
	Note: You must continue to pay your Part B premium. Plan changes are effective only on the first of the month. The plan change may not be effective prior to Medica's receipt of the change form.
	I want to transfer from my current plan to the plan I have selected below. **STANDARD, BASIC, THRIFT OR ENHANCED** You must reside in one of the following counties: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse or Yellow Medicine. Medical + Part D Coverage: ❍ Standard w/ Rx: $49.30/month ❍ Basic w/ Rx: $134.00/month ❍ Basic w/ Rx 2: $172.40/month ❍ Thrift w/ Rx: $79.70/month ❍ Enhanced w/ Rx 2: $247.40/month

3	PLEASE CAREFULLY READ THE FOLLOWING STATEMENTS

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

Please read the following statements carefully and check the circle if the statement applies to you. By checking any of the following circles 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.

❍ Leaving or left employer or union coverage on __ / __ / __ (date).

❍ Enrolled in a plan by Medicare (or my state) and want to choose a different plan. My enrollment in that plan started on __ / __ / __ (date).

❍ 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.

❍ Recent change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, change in level of Extra Help or lost Extra Help) __ / __ / __ (date).

❍ Recent change to a State Pharmacy Assistance Program (newly enrolled in or lost SPAP).

❍ Losing or lost prescription drug coverage on __ / __ / __ (date).

❍ Permanent residence changed; moved from _____ / ____ or _____ on __ / __ / __ (date).
County State Country

❍ Moving into, live in, or moved out of a Long-Term Care Facility on __ / __ / __ (date).

❍ Left a Program of All-Inclusive Care for the Elderly (PACE) on __ / __ / __ (date).

❍ Weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applies, but was unable to make enrollment because of natural disaster.

4 PREMIUM PAYMENT METHOD

Please do not submit payment with your application.

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

Note: 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 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 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medica.

Please choose a payment method:

❍ Continue my current payment method (if you do not make a new selection below, your current method will continue)

❍ Start monthly invoicing

❍ Start monthly automatic withdrawals from your checking or savings account

Withdrawals take place on the fifth business day of each month.

Account Type:	Account Holder Name
❍ Checking (attach a voided check) ❍ Savings (attach a deposit slip)	

❍ Start Social Security or Railroad Retirement Board deduction

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 not include all premiums due from your enrollment effective date up to the point withholding begins. **We will send you a paper invoice for those months before the deduction starts.** 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 my monthly benefits from: ❍ Social Security ❍ RRB

5	SIGN & DATE

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

Medica Prime Solution with Rx is a Medicare health plan with a Medicare prescription 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 B coverage. It is my responsibility to inform Medica 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 Medica Prime Solution with Rx will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Medica Prime Solution with Rx serves a specific service area. If I move out of the area that Medica Prime Solution with Rx 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 Medica Prime Solution with Rx network pharmacies. Once I am a member of Medica Prime Solution with Rx, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medica Prime Solution with Rx, when I receive it, to know which rules I must follow to receive coverage with this Medicare health plan.

Beginning on the date Medica Prime Solution coverage starts, I must receive all of my health care from Medica-contracted providers to receive the highest level of benefits, with the exception of emergency or urgently-needed services or for out-of-area renal dialysis. If I obtain routine services from non-network providers that are not authorized for coverage by Medica under the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medica, he/she may be compensated based on my enrollment in Medica Prime Solution with Rx.

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.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Medica and other services contained in my Medica Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

5	SIGN & DATE

Release of Information:

By joining this Medicare health plan, I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), health plans, brokers of record, providers and any other person or entity to share my health information (except for psychotherapy notes, or chemical dependency records, unless permitted by law) with each other as is necessary for treatment, payment and health care operations. I also acknowledge that Medica 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 further understand that I have the right to revoke this authorization, at any time, by contacting Medica in writing. Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. However, if I revoke this authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization remains in effect until termination of coverage.

I understand that my signature (or the signature of the person authorized to act on my behalf under the state law where I live) on this application means I have read and understand the contents of this application. **I understand that by changing my plan option, my benefits, premiums and automatic payment will change.** 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 by Medica or by Medicare.

X _____ ___ / ___ / ___

Applicant or Authorized Representative Signature Today's Date

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

Name:	Phone Number:
Address:	Relationship to Enrollee:

PO Box 9310, Minneapolis, MN 55440-9310