Medica Prime Solution® (Cost) Plan with Part D
—North and South Dakota Residents

2019 Enrollment Application Form — North Dakota and South Dakota Residents

Part D Options for Thrift, Core and Premier

This form is for Medica Prime Solution members who are adding Medica Part D to their existing medical benefits. This form may not be used to enroll in Medica Prime Solution for the first time or to change your Medical or Part D plan.

Important Information

- Please consult your Summary of Benefits for more details on the Medica Part D options available.
- If you have any questions concerning your application or if you need information in another language or format (like Braille or large print), please contact Medica from 8 a.m. to 8 p.m. Central, seven days a week at 1-800-918-2143 (TTY: 711).
- The premium for the Medica Part D is added to your Medica Prime Solution medical premium.
- If you currently have prescription drug coverage from an employer or union, joining this Medica Prime Solution Part D drug plan may affect your employer or union health benefits, and may change how your current coverage works. If you have questions, contact your benefits administrator or the office that answers questions about your coverage.
- If you are assessed a Part D-Income Related Monthly Adjustment Amount (PART D-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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to Medica.
- If you qualify for “Extra Help” with your Medicare prescription drug costs, Medicare will pay all or some portion of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare does not cover.
- To enroll, please make sure you have completed and forwarded all necessary information to Medica. Complete all sections of the application in full. Missing or partial information may cause a delay in the effective date of your coverage. Use a black or blue pen and print firmly.

Return completed applications to: OR Fax to: OR Securely upload online at:

Medica Medicare Solutions 1-855-250-2166 medica.com/EnrollmentUpload
PO Box 6300
Eau Claire, WI 54702-9713
2019 Medica Part D Options Enrollment Application Form

Section 1: Please print your name exactly the way it appears on your Medicare card

<table>
<thead>
<tr>
<th>Legal First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
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Select one:
- □ Male
- □ Female

Permanent Residence Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
<th>County</th>
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Mailing Address if different from above

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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Medica Member ID Number required

Primary Telephone with area code

Birthdate

(Example: 07/11/1990)

Email Address optional – by providing you agree that Medica may send you emails

Section 2: Effective date and plan selection

I request an effective date for the first day of __________________________, 2019.

Select Medical + Part D coverage

- □ Thrift w/Rx: $80.90 / month
- □ Core w/Rx: $115.70 / month
- □ Premier w/Rx: $229.50 / month

Section 3: Please answer these questions

This information is required to process your application and is NOT used for health screening

□ YES □ NO

On the effective date you requested, will you have other (non Part D) prescription drug coverage in addition to the Medica Part D such as VA benefits, TRICARE, Federal employee health benefits coverage, State Pharmaceutical Assistance Program (SPAP), or other private insurance?

If YES, please provide the following information:

Name of Coverage: ______________________________________________

Group No.: ________________________ ID No.: ________________________
Section 4: Carefully read the following statements

Check all that apply. By checking any of the statements below, you represent that, to the best of your knowledge and belief, you are eligible for a Special Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- Current Medicare Cost or Medicare Advantage plan is not renewing
- Leaving or left employer or union coverage on __ / __ / __ Date
- Recent change in Medicaid (newly enrolled, change in level of Medicaid Assistance, or lost Medicaid) __ / __ / __ Date
- Disenrolling or disenrolled from a Medigap plan 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
- Belong to a state pharmacy assistance program
- Permanent residence changed; moved from __________________ / ____________ / ____________
  County                  State
  or __________________
  Country
  on __ / __ / __ Date
- Live in a Long-Term Care Facility
- Moving into 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.

Section 5: Sign and date

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I acknowledge, accept receipt of, and understand the meaning of this application, the statements of understanding on page 4 of this application, and the Medica Prime Solution Summary of Benefits. If signed by an authorized individual (as described above), this signature represents that, to the best of that individual’s knowledge and belief: 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: __________________________ Address: __________________________

Telephone Number: __________________________ Relationship to Enrollee: __________________________

Agent use only

_________________________ ID Number

X __________________________

Agent Signature __ / __ / __

Agent Telephone ____________

Agent’s Receipt Date __________________________
Statements of Understanding

By completing Section 5, I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), plans, brokers of record, providers and any other person or entity to share my health information with each other as is necessary for treatment, payment and health care operations. I also authorize this information to be released to Medicare who may release it for research and other purposes which follow all applicable federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable privacy rules. 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 further understand and agree that:

1. Medica Prime Solution Part D coverage is a Medicare drug plan.

2. Generally, I may leave this Medica Prime Solution Part D drug plan only at certain times of the year, or under certain special circumstances, by sending a written request to Medica or 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.

3. 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 the Medica Part D will end that enrollment.

4. Medica Prime Solution serves a specific service area. It is my responsibility to tell Medica before I permanently move, leave the service area for more than 90 consecutive days, or, if I have activated the Extended Absence Option, for more than 9 consecutive months. I understand that my absence means that Medica Prime Solution may take action to disenroll me and return me to traditional Medicare coverage.

5. Medica Prime Solution will send me written notification of the effective date of my enrollment.

6. I have the right to appeal plan decisions about payment of coverage for services with which I disagree. I will read the Evidence of Coverage document from Medica when I receive it to know which rules I must follow in order to receive coverage under Medica Prime Solution. The premium and copayment amounts were stated to me, and may also be found in the Evidence of Coverage.

7. If I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Medica, he/she may be paid based on my enrollment in the Medica Part D.

The information on this 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.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

Medica is a Cost plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

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