Bright HealthCare™

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 1-844-926-4521, TTY 711.

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 brighthealthcare.com/medicare or call 1-844-926-4521, TTY 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/co-insurance may change on January 1, 2022.
- ☐ 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).
- ☐ This plan is a chronic condition special needs plan (CSNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

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

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

1. **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).

2. **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.

3. **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.

4. **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 or your monthly Social Security (or Railroad Retirement Board) benefit.

5. **What happens next?**
   Send your completed and signed form to:
   Bright HealthCare Medicare Advantage - Enrollment
   P.O. Box 1731
   Portland, ME 04104
   FAX: 1-877-346-0321

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

6. **How do I get help with this form?**
   Call Bright HealthCare Advantage Health Plan at 1-844-926-4521. TTY users can call 711. The Member Services Department is available Monday – Friday 8 am – 8 pm and 7 days a week 8 am – 8 pm from October 1 – March 31, excluding federal holidays.

   Or, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users can call 1-877-486-2048.

   En español: Llame a Bright HealthCare Advantage Health Plan al 1-844-926-4520, TTY 711 (o a Medicare gratis al 1-800-633-4227, 24 horas al día/7 días a la semana) y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.
   Bright HealthCare está disponible de lunes a viernes de 8 am – 8 pm y los 7 días de la semana de 8 am – 8 pm del 1 de octubre al 31 de marzo, excluyendo feriados federales.

New York

Bright HealthCare™

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

Proposed Effective Coverage Date:

Select the plan you want to join:

Bright Advantage Dual Access Plan (HMO D-SNP) H2288-003

☐ Kings, New York, and Queens counties

$0 per month*

*Your premium may be more if you are not receiving Extra Help

Bright Advantage Embrace Choice Plan (HMO C-SNP) H2288-010

☐ Kings, New York, and Queens counties

$0 per month*

*Your premium may be more if you are not receiving Extra Help

Bright Advantage Embrace Care Plan (HMO C-SNP) H2288-009

☐ Kings, New York, and Queens counties

$0 per month

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

FIRST Name:	LAST Name:	Middle Initial (Optional):
Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F	Phone Number: __ __ __ – __ __ __ – __ __ __ __

Permanent Residence Street Address (Don't enter a P.O. Box):

City:	County (Optional):	State:	ZIP Code:

Mailing Address, if different form your Permanent Address (P.O. Box allowed):

City:	State:	ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Bright HealthCare Medicare Advantage plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

To qualify for a Bright Advantage Embrace Chronic Condition Special Needs Plan (C-SNP), you must have one or more of the below chronic conditions.

Have you been diagnosed with one of the following? Please check all that apply.

☐ Congestive heart failure (CHF) ☐ Cardiovascular disease (CVD) ☐ Diabetes mellitus (DM)

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.

To qualify for Bright Advantage Dual Access Plan (HMO D-SNP), Medicaid eligibility must be verified. Your Medicaid eligibility status must be QMB, QMB-Plus or Full Medicaid Only.

Do you have Medicaid? ☐ Yes ☐ No

What is your Medicaid Number?_____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Bright HealthCare Medicare Advantage plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Bright HealthCare Medicare Advantage plan will share my information with 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 when my Bright HealthCare Medicare Advantage plan coverage begins, I must get all of my medical and prescription drug benefits from Bright HealthCare Medicare Advantage plan. Benefits and services provided by Bright HealthCare Medicare Advantage plan and contained in my Bright HealthCare Medicare Advantage plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Bright HealthCare Medicare Advantage plan will pay for benefits or services that are not covered.
- 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: _____

Office Use Only:

Name of staff member/broker (if assisted in enrollment):_____

Agent NPN:_____

Plan ID#:_____Effective Date of Coverage:_____

ICEP/IEP:_____AEP:_____SEP (type):_____Not Eligible:_____

Broker received date:_____

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.

☐ Chinese ☐ Korean ☐ Spanish ☐ Other_____

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Bright HealthCare Medicare Advantage plan at **1-844-926-4521** 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. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays. TTY users can call **711**.

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.

☐ I want to get plan materials electronically when available. I understand that I can request a paper copy at any time.

Email address: _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Section 2 (Continued) – All fields on this page are optional

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 or "Electronic Funds Transfer (EFT)" 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 Bright HealthCare the Part D-IRMAA.

Please select a premium payment option

☐ **Monthly Invoice**

☐ **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 account number: _____

Account Type: ☐ Checking ☐ Saving

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) 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 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.

Exhibit la: Information to include on or with Enrollment Mechanism- Attestation of Eligibility for an Enrollment Period

Referenced in section: 30.4
(Rev. 2, Issued: August 25, 2020; Effective/Implementation: 01-01-2021)

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 am enrolled in a plan that was placed in receivership.
- ☐ I am enrolled in a plan that has been identified by CMS as a consistent poor performer.
- ☐ I have other extenuating circumstances.
- ☐ 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact Bright HealthCare at 1-844-926-4521 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m. local time, 7 days a week, Oct. 1st – Mar. 31st; 8:00 a.m. to 8:00 p.m. local time, Apr. 1st-Sept. 30, excluding federal holidays.

Bright HealthCare™

Bright HealthCare Pre-Enrollment Qualification Assessment Tool

IMPORTANT: Complete if Enrolling in a Bright Advantage Embrace Chronic Condition Special Needs Plan

Bright Advantage Embrace Chronic Condition Special Needs Plans (C-SNPs) are for individuals with diabetes, congestive heart failure and certain cardiovascular disorders. To enroll in these plans, Medicare requires that Bright HealthCare verify your chronic condition. This is a two-step process:

Step One

Please complete this form and return it to us with your completed enrollment application. If you can answer "yes" to at least one of the chronic condition questions, you may pre-qualify for enrollment in a Bright Advantage Embrace C-SNP.

Step Two

Bright HealthCare must verify your chronic condition within one month of your enrollment. Note: If we are unable to verify your chronic condition, we must disenroll you from the C-SNP. That is why it is important to give us contact information for a doctor or clinic that can verify your condition (see page 3 of this form).

Applicant information		
LAST Name:	FIRST Name:	Middle Initial (Optional):
Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Medicare Number: __ __ __ __ – __ __ __ – __ __ __ __	
Phone Number: __ __ __ – __ __ __ – __ __ __ __	Alternate Phone Number (cell): __ __ __ – __ __ __ – __ __ __ __	
☐ By checking this box, you authorize Bright HealthCare and its affiliates to send you text messages with information related to your health plan.		
Email address: _____ ☐ By checking this box, you authorize Bright HealthCare and its affiliates to send you information related to your health plan by email.		

Chronic Condition Questions

Diabetes Mellitus (DM) (Note: a pre-diabetes diagnosis does not qualify for this plan)

1. Have you ever been told by a doctor that you have diabetes? ☐ Yes ☐ No
2. Do you take or has your doctor prescribed insulin or another medication for diabetes treatment? ☐ Yes ☐ No
3. Have you been put on a special diet by your doctor or a registered dietician to treat your diabetes? ☐ Yes ☐ No

Congestive Heart Failure (CHF)

1. Have you ever been told by a doctor that you have congestive heart failure (CHF)? ☐ Yes ☐ No
2. Do you take medication to prevent fluid build-up in your lungs or have you had problems with fluid in your lungs or swelling in your legs, accompanied by shortness of breath, due to a heart problem? ☐ Yes ☐ No
3. During the past 12 months, have you been counseled or educated by a health care professional about weighing yourself daily to monitor a heart problem? ☐ Yes ☐ No

Cardiovascular Disorder (CVD)

1. Have you ever been told by a doctor that you have any of the following?
   a. Cardiac arrhythmia (heart rhythm problems like atrial fibrillation ("AFib") or rapid or irregular heartbeats) ☐ Yes ☐ No
   b. Coronary artery disease (heart disease) ☐ Yes ☐ No
   c. Blood clots or blood circulation problems in your legs (peripheral vascular disease) ☐ Yes ☐ No
   d. Chronic venous thromboembolic disorder (blood clots in your veins) ☐ Yes ☐ No
2. Have you ever had a stroke? ☐ Yes ☐ No
3. Have you ever had a heart attack or a stent placement? ☐ Yes ☐ No

Health care provider(s) who can verify your chronic condition(s)

Provider #1	Provider #2
Provider Name:	Provider Name:
Provider Phone Number: __ __ __ – __ __ __ – __ __ __ __	Provider Phone Number: __ __ __ – __ __ __ – __ __ __ __
Provider Fax Number: __ __ __ – __ __ __ – __ __ __ __	Provider Fax Number: __ __ __ – __ __ __ – __ __ __ __
Clinic Location:	Clinic Location:

Authorization for use and disclosure of health information to verify chronic condition(s) for purpose of health plan eligibility

I authorize the providers listed above to disclose my health information to Bright HealthCare to verify that I have been diagnosed with a chronic condition that qualifies me for enrollment in a Bright HealthCare Chronic Condition Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth above, consistent with state and federal law concerning the privacy of such information.

Applicant Name (printed): _____

Applicant/Authorized Representative Signature: _____

Date: _____

To be completed by provider or provider representative

Provider Attestation
For the purpose of confirming eligibility to enroll in a Chronic Condition Special Needs Plan, I hereby attest that the Applicant identified above has the following health condition(s):

- Diabetes Mellitus (DM) (pre-diabetes excluded) ☐ Yes ☐ No
- Congestive Heart Failure (CHF) ☐ Yes ☐ No
- Cardiovascular Disorder (please specify the CVD):
  - – Cardiac arrhythmia ☐ Yes ☐ No
  - – Coronary artery disease ☐ Yes ☐ No
  - – Peripheral vascular disease ☐ Yes ☐ No
  - – Chronic venous thromboembolic disorder ☐ Yes ☐ No

Provider Name (printed): _____

Provider or Provider Representative Signature: _____

Today's Date: _____

Please return this form to Bright HealthCare within three (3) business days of receipt

By Fax:
1-877-346-0321
ATTN: Bright HealthCare Medicare Advantage – Enrollment

By Mail:
Bright HealthCare Medicare Advantage – Enrollment
P.O. Box 1731
Portland, ME 04104

If you have any questions about this form, please call: **1-844-926-4522**, 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays.