SummaCare℠
Health Insurance

2025 Medicare Advantage Prescription Drug Plan

Plan Change Request Form

Your Information

I am **currently** a member of the _____ plan in SummaCare with a monthly premium of $_____. I would like to switch my membership to the plan that I've indicated below:

O Topaz (HMO) $0/month
O Jade (HMO)* $12/month
O Garnet (HMO) $24/month
O Ruby (HMO) $48/month
O Sapphire (HMO-POS) $80/month
O Emerald (HMO-POS) $152/month

If you enroll in the Topaz, Jade, Garnet or Ruby HMO plans, you must use the SC*Medicare* network for all of your medical care, except for emergency or urgent care services and out-of-area renal dialysis services.

First Name: _____ Last Name: _____ Middle Initial (Optional): _____
Birth Date (MM/DD/YYYY):_____ Sex: **O** M **O** F Phone Number: _____

Permanent Residence Street Address (Don't enter a PO Box. For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):
Street Address: _____
City: _____ County: _____ State: Ohio Zip Code: _____

Mailing Address, if Different from Your Permanent Address (PO Box Allowed):
Street Address: _____
City: _____ State: _____ Zip Code: _____

Medicare Number (as it appears on your Medicare card):_____

SummaCare Member ID Number (as it appears on your SummaCare card):_____

Please indicate whether you'd like to enroll in the optional supplemental dental plan.
Optional Supplemental Dental: If you are currently enrolled in the optional supplemental Delta Dental of Ohio plan and you are switching to a different SummaCare Medicare Advantage plan, you will need to **RE-ENROLL** in the optional supplemental Delta Dental plan by checking the "YES" box below to ensure continuation of your supplemental dental coverage:

O YES, I would like to enroll in the optional supplemental dental plan. **I understand that I will be billed an additional $37 each month for this coverage.**

O NO, I do not want to enroll in the optional supplemental dental plan. **I understand that I can still enroll in this optional coverage up to 30 days after my plan is effective.**

Requested Effective Date: (generally the first day of the month after form is received):
(Month)_____, 2025

ONLY COMPLETE THE SECTION BELOW IF YOU HAVE SELECTED THE JADE (HMO) PLAN

The Jade (HMO) plan allows you to choose from a list of supplemental benefits. For more information about each benefit, see the Bene-Flex™ section of the Summary of Benefits. Please choose **five** options across the three tiers below to create your Bene-Flex bundle. Please note that the benefits with an asterisk require a certain diagnosis required for enrollment.

Tier 1 — Pick 3	Tier 2 — Pick 1	Tier 3 — Pick 1
O Fitness Tracker	O SilverSneakers®	O Flex Card for Vision, Dental & Hearing
O Toenail Trimming	O Massage Therapy*	O Papa Pals
O BrainHQ Memory Fitness	O Transportation	O Healthy Grocery Allowance***
O Acupuncture	O Air Purifier**	O PERS (Personal Emergency Response System)
O Chiropratic Care	O Post-Discharge Meal Delivery	O Home Safety Devices
O Nutrition Coaching	O Chronic Care Meal Delivery***	

*This benefit requires a doctor's order in order to be chosen/utilized.

**This benefit is part of a special supplemental program for the chronically ill; members must have a diagnosis of asthma and/or COPD – including chronic bronchitis and/or emphysema to choose/utilize it.

***These benefits are part of a special supplemental program for the chronically ill; members must have a diagnosis of diabetes mellitus type 1 or type 2, congestive heart failure, chronic kidney disease, COPD, coronary artery disease, chronic non-alcoholic fatty liver disease, autoimmune disease, chronic and disabling mental health conditions, or neurologic disorders to choose/utilize it.

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

Are you Hispanic, Latino/a or Spanish origin? Select all that apply.

O NO, not of Hispanic, Latino/a, or Spanish origin
O YES, Mexican, Mexican American, Chicano/a
O YES, another Hispanic, Latino/a, or Spanish origin
O YES, Cuban
O YES, Puerto Rican
O **I choose not to answer**

What's your race? Select all that apply.

O American Indian or Alaska Native
O Asian Indian
O Black or African American
O Chinese
O Filipino
O Guamanian or Chamorro
O Japanese
O Korean
O Native Hawaiian
O Other Asian
O Other Pacific Islander
O Samoan
O Vietnamese
O White
O **I choose not to answer**

What's your gender? Select one.

O Woman O Man O Non-binary O I use a different term: _____
O **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

O Lesbian or gay O Straight, that is not gay or lesbian O Bisexual
O I use a different term: _____ O I don't know O **I choose not to answer**

Do you want us to send you information in a language other than English? O Yes O No

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

O Spanish O Chinese O German O Arabic O Pennsylvania Dutch
O Russian O French O Vietnamese O Cushite/Oromo O Korean
O Italian O Japanese O Dutch O Ukrainian O Romanian O Nepali

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

O Braille **O** Large Print **O** Audio CD **O** Data CD

Please contact SummaCare at **888.464.8440** 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., seven days a week, from October 1 through March 31 and 8 a.m. to 8 p.m., Monday – Friday, from April 1 through September 30. TTY users should call **711**.

Do you work? **O** Yes **O** No **Does your spouse work?** **O** Yes **O** No

Your Plan Premium

- If you previously qualified for Medicare prescription drug coverage, but decided not to carry prescription drug coverage at least as good as Medicare's, then Medicare may determine that you owe a monthly late enrollment penalty.
- If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), it will be included in your monthly premium, even if you sign up for a $0 premium plan. If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by any of the following methods: You can receive a paper invoice in the mail each month and mail SummaCare a check for the premiums due. You can pay your bill automatically each month from a checking or savings account using Electronic Funds Transfer (EFT). You can pay your bill automatically each month using a VISA, MasterCard or Discover card. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. No matter which method you select, you must continue to pay your Part B premium to Social Security in addition to the SummaCare plan premium. If you are assessed a Part D- Income Related Monthly Adjustment Amount (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 benefit check or be billed directly by Medicare or the RRB. DO NOT pay SummaCare the Part D-IRMAA.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 **800.772.1213**. TTY users should call **800.325.0778**. You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help**.
- If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.
- If you don't select a payment option, you will get a bill each month.
- If you have recently been enrolled in Medicaid or you have received a letter stating that you have qualified for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) status, you automatically qualify for Prescription Drug Assistance. If you need a prescription filled before SummaCare receives confirmation from the Centers for Medicare and Medicaid Services (CMS) of your eligibility status, please contact our Member Services department at **800.996.6250 (TTY 711)** for assistance. The qualifications for Prescription Drug Assistance are based on income and assets.

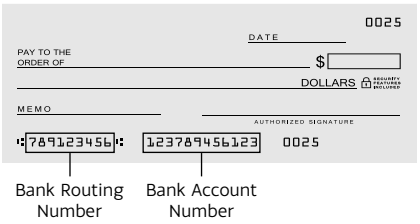
Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) using one of the following payment methods below.

If you do not select a payment option, we will mail you a bill each month.

O Get a monthly bill in the mail.

U.S. Checks



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

Account Holder Name: _____

Banking Routing Number: _____

Bank Account Number: _____

Account Type: **O** Checking **O** Savings

O Credit Card. Electronic charges to your VISA, MasterCard or Discover each month. Please provide the following information:

Type of Card: **O** VISA **O** MasterCard **O** Discover

Name of Account Holder as it appears on card: _____

16-digit Credit Card Number: _____

CVV Number (3-digit code on back of card): _____ Expiration Date (MM/YY): _____

O Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check*

I get monthly benefits from: **O** Social Security **O** Railroad Retirement Board

PLEASE NOTE: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, the effective date of the deduction will NOT be the same as your enrollment effective date with SummaCare. SummaCare will send you a monthly bill in the mail until we receive notification from Medicare as to which month they begin taking the money out of your Social Security check. You are responsible for paying by check until such time as we have established the effective date of your withhold.

*You should know that Social Security LIMITS the automatic deduction amount allowed from your benefit check to $300. For example, should you select the SummaCare Medicare Emerald plan and there is a two-month delay in processing, the entire transaction will be rejected by Social Security because the deduction amount would exceed $300. You will then default back to being billed by mail for all unpaid premiums.

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 SummaCare the Part D-IRMAA.

IMPORTANT: Read and Sign Below

- SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal.
- I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with SummaCare, they may be paid based on my enrollment in SummaCare.
- Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans or providers as is necessary for treatment, payment and health care operations. I also acknowledge that SummaCare 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 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 SummaCare provides medical and prescription drug coverage when I travel and I will have emergency coverage if I travel outside of the U.S. I understand that services requiring an authorization will be denied if no authorization information is received from the doctor.
- I understand that beginning on the date SummaCare coverage begins and if I enroll in a SummaCare HMO plan, I must use SC*Medicare* providers for all my medical care, except for emergency or urgently needed services or out-of-area renal dialysis services. I understand that beginning on the date SummaCare coverage begins and if I enroll in a SummaCare HMO-POS plan, I can receive care from any Medicare-approved provider, but my out-of-pocket costs may be higher if I see providers outside of the SC*Medicare* network. Out-of-network/non-contracted providers are under no obligation to treat SummaCare members, except in emergency situations. Please call our member services number on the back of your ID card or see your Evidence of Coverage for more information including the cost-sharing that applies to out-of-network services.
- I understand that services requiring an authorization will be denied if no authorization information is received from the doctor. Services authorized by SummaCare and other services contained in my SummaCare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR SUMMACARE WILL PAY FOR THE SERVICES. Please note: All SummaCare Medicare Advantage plans include Visitor/Travel Coverage. Refer to the Summaries of Benefits and/or your Evidence of Coverage (EOC) for more information.
- 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.

Signature: _____ **Today's Date:** _____

If you are the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Signature: _____ Date: _____

Relationship to enrollee: _____

National Producer Number (Agents/Brokers only): _____

Broker Code: _____

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.

- **O** I am new to Medicare.
- **O** I am enrolling during the Annual Enrollment Period from October 15 to December 7.
- **O** I have had Medicare prior to now, but am just turning age 65.
- **O** I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- **O** 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): _____.
- **O** I recently was released from incarceration. I was released on (insert date): _____.
- **O** I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): _____.
- **O** I recently obtained lawful presence status in the United States. I got this status on (insert date): _____.
- **O** 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): _____.
- **O** 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): _____.
- **O** 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.
- **O** 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): _____.
- **O** I recently left a PACE program on (insert date): _____.
- **O** I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): _____.
- **O** I am leaving employer or union coverage on (insert date): _____.
- **O** I belong to a pharmacy assistance program provided by my state.
- **O** My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- **O** 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): _____.
- **O** 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): _____.
- **O** 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 SummaCare at **888.464.8440** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. until 8 p.m., seven days a week, from October 1 through March 31 and 8 a.m. until 8 p.m., Monday – Friday, from April 1 through September 30. SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal. H3660_SC1178_C Approved 10172024

SummaCare SM

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