ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

2020 MEDICARE ENROLLMENT REQUEST FORM

FOLLOW THESE STEPS TO COMPLETE YOUR ENROLLMENT FORM:

Step 1: Choose your plan

- Advantage MD (HMO) is available in the following counties: Anne Arundel County, Baltimore County, Baltimore City, Calvert County, Carroll County, Frederick County, Howard County, Montgomery County, Somerset County, Washington County, Wicomico County, and Worcester County.
- Advantage MD (PPO) and Advantage MD Plus (PPO) are available in the following counties: Anne Arundel County, Baltimore County, Baltimore City, Calvert County, Carroll County, Frederick County, Howard County, Somerset County, Washington County, Wicomico County, and Worcester County. (Not available in Montgomery County.)
- Advantage MD Premier (PPO) is available in Montgomery County only.

Step 2 and 3: Fill in your address and Medicare information
Step 4: Choose how to pay your premium
Step 5 and 6: Answer important questions and choose your provider
Step 7: Read carefully, sign and return the form in the postage-paid envelope

HELPFUL HINTS

- Call Johns Hopkins Advantage MD if you need help selecting a primary care provider
- Return you application in the self-addressed envelope provided or mail your application to: Johns Hopkins Advantage MD P.O. Box 3538 Scranton, PA 18505
- You can also fax your application to 1-855-825-7723
- Do not mail your payment with your application.

NEED HELP? WANT TO ENROLL FASTER?

CALL NOW: 1-888-403-7662 (TTY: 711)

8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 – September 30, you will need to leave a message on weekends and holidays. Or, go to HopkinsMedicare.com to review plan information and enroll online.

NEXT STEPS:

Once your enrollment is accepted by the Centers for Medicare & Medicaid Services, we will send you an enrollment letter, your new member materials and your Johns Hopkins Advantage MD ID card. If your income is limited, you may qualify for Extra Help to pay for prescription drug costs. You can apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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Please contact Johns Hopkins Advantage MD at 1-888-403-7662 (TTY: 711) if you need information in another language or format (Braille). Our office hours are 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 – September 30, you will need to leave a message on weekends and holidays.

1. Select your Plan

PLEASE CHECK THE PLAN YOU WANT TO ENROLL IN:

HMO Plans	Plan Premium	Plan Premium + Optional Supplemental Benefit*
Johns Hopkins Advantage MD (HMO) (Baltimore City only)	◯ $0 per month	◯ $30 per month *Includes fitness and comprehensive dental*
Johns Hopkins Advantage MD (HMO) *(Available throughout our service area)*	◯ $25 per month	◯ $55 per month *Includes fitness and comprehensive dental*
PPO Plans	**Plan Premium**	**Plan Premium + Optional Supplemental Benefit***
Johns Hopkins Advantage MD (PPO) *(Not available in Montgomery County)*	◯ $75 per month	◯ $105 per month *Includes fitness and comprehensive dental*
Johns Hopkins Advantage MD Plus (PPO) *(Not available in Montgomery County)*	◯ $105 per month *Includes fitness benefit at no extra cost*	◯ $133 per month *Includes comprehensive dental (Fitness included in plan premium)*
Advantage MD Premier (PPO) *(Montgomery County only)*	◯ $350 per month *Includes fitness and comprehensive dental at no extra cost.*	

* Please see the Summary of Benefits for more information about Optional Supplemental Benefits.

2. Provide the following information

Last Name: **First name:** **Middle Initial:** ◯ **Mr.** ◯ **Mrs.** ◯ **Ms.**

Birth Date: **Sex:** **Primary Phone Number:** **Alternate Phone Number:**

(___ / ___ / ____) (MM / DD / YYYY) ◯ M ◯ F _____ ☐ cell phone _____ ☐ cell phone

Email address: (Optional):

Permanent Residence Street Address (P.O. Box is not allowed):

City: **County:** **State:** **Zip Code:**

Mailing Address (*only if different from your permanent residence address*):

City: **County:** **State:** **Zip Code:**

OPTIONAL INFORMATION

Emergency Contact: **Relationship to you:** **Phone number:**

3. Please provide your Medicare insurance 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:

_____

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. Paying your plan premium

Advantage MD HMO (Baltimore City only): 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 by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

Advantage MD HMO, Advantage MD PPO, Advantage MD Plus and Advantage MD Premier: 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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (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 RRB. **DO NOT pay Johns Hopkins Advantage MD the Part D-IRMAA.**

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 co-insurance. 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.

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. 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.**

As a Maryland resident, you may also qualify for the Senior Prescription Drug Assistance Program (SPDAP). For more information, call 1-800-551-5995 (TTY 1-800-877-5156) Monday – Friday from 8:00 am to 5:00 pm. Visit them online at http://marylandspdap.com/.

Please select a premium payment option. **If you do not select a payment option, you will receive a monthly bill.**

☐ **Electronic funds transfer (EFT) from your bank account each month.**

- The EFT enrollment process usually takes 4-5 weeks. While you are waiting for EFT, you will receive monthly statements. You must pay your premium directly to **Johns Hopkins Advantage MD at P.O. Box 419169, Boston, MA 02241-9169.**

Please enclose a VOIDED check or provide the following:

Account holder name _____

Bank routing number _____ Bank account number_____

Account type:
◯ Checking
◯ Savings

☐ **Automatic deduction from your monthly Social Security or 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.

☐ **Get a monthly bill.**

Payments are due on the first of each month. Make your check, cashier's check or money order payable to **Johns Hopkins Advantage MD** and mail directly to **Johns Hopkins Advantage MD, P.O. Box 419169, Boston, MA 02241-9169.**

5. Please read and answer these important questions

1. Do you have End-Stage Renal Disease (ESRD)? ◯ **Yes** ◯ **No**

   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Johns Hopkins Advantage MD?

   ◯ **Yes** ◯ **No**

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____ *ID # for this coverage:* _____ *Group # for this coverage:* _____

3. Are you a resident in a long-term care facility, such as a nursing home? ◯ **Yes** ◯ **No**

   If "yes," please provide the following information:

   Name of Institution: _____

   Address & Phone Number of Institution (number and street): _____

   _____

4. Are you enrolled in your State Medicaid program? ◯ **Yes** ◯ **No**

   If "yes," please provide your Medicaid number: _____

5. Do you or your spouse work? ◯ **Yes** ◯ **No**

6. Please choose the name of a Primary Care Physician (PCP), clinic or health center: PCP ID/Contact ID#:

   _____ _____

   Are you a current patient of this PCP? ◯ **Yes** ◯ **No**

   Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

   ☐ Language _____

   ☐ Braille, audio tape, or large print _____

   Please contact Johns Hopkins Advantage MD at 1-888-403-7662 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are, 8 a.m. – 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30 the hours are 8 a.m. to 8 p.m., Monday – Friday. On weekends and holidays you will need to leave a message.

6. Attestation of eligility 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 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 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 Johns Hopkins Advantage MD at 1-888-403-7662. (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m., 7 days a week October 1 to March 31. From April 1 to September 30 the hours are 8 a.m. to 8 p.m., Monday – Friday. On weekends and holidays you will need to leave a message.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Johns Hopkins Advantage MD could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Johns Hopkins Advantage MD. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.check each month.

Johns Hopkins Advantage MD is a Medicare Advantage Plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD HMO or PPO depends on contract renewal.

7. Please read and sign below

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

Johns Hopkins Advantage MD is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Johns Hopkins Advantage MD serves a specific service area. If I move out of the area that Johns Hopkins Advantage MD serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Johns Hopkins Advantage MD, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Johns Hopkins Advantage MD when I get it to know which rules I must follow to get coverage with this Medicare Advantage 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.

- **For membership in Johns Hopkins Advantage MD HMO:** I understand that beginning on the date Johns Hopkins Advantage MD coverage begins, I must get all of my health care from Johns Hopkins Advantage MD network providers, except for emergency or urgently needed services or out-of-area dialysis services.
- **For membership in Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) or Advantage MD Premier (PPO):** I understand that beginning on the date Johns Hopkins Advantage MD coverage begins, using services in-network can cost less than using services out- of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Johns Hopkins Advantage MD provides refunds for all covered benefits, even if I get services out of network.

Services authorized by Johns Hopkins Advantage MD and other services contained in my Johns Hopkins Advantage MD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR JOHNS HOPKINS ADVANTAGE MD WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Johns Hopkins Advantage MD, he/she may be paid based on my enrollment in Johns Hopkins Advantage MD.

Release of Information: By joining this Medicare health plan, I acknowledge that Johns Hopkins Advantage MD will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Johns Hopkins Advantage MD 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 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, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (____ **)** ____ **-** ____ **Relationship to Enrollee:** _____

Agent Use Only:

Name of agent (if assisted in enrollment): _____

Agent Code: _____

FMO Name: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Date: _____