



Member Name: \_\_\_\_\_

Member Number (Printed on your MedicareBlue Rx ID card): \_\_\_\_\_

Medicare ID Number (Printed on your red, white and blue Medicare ID card): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Please check the appropriate box below, indicating which plan option you wish to change to:**

**MedicareBlue Rx Option 1**

**Premium** - \$24.70/mo.

**Deductible** - \$275

**Coinsurance** - (In-network)

- Level 1: Generic 10%
- Level 2: Preferred brand 18%
- Level 3: Brand 50%
- Specialty Drugs 25%

**Coverage Gap** - You pay 100% between \$2,510 – \$4,050 in total covered drug costs.

**Catastrophic Coverage** -

After \$4,050 out-of-pocket, you pay the greater of:

- \$2.25 for generic / \$5.60 for other covered drugs or
- 5% coinsurance

**MedicareBlue Rx Option 2**

**Premium** - \$62.50/mo.

**Deductible** - \$0

**Copay/Coinsurance** - (In-network)

- Level 1: Generic \$4
- Level 2: Preferred brand \$32
- Level 3: Brand 50%
- Specialty Drugs 33%

**Coverage Gap** - You pay 100% between \$2,510 – \$4,050 in total covered drug costs.

**Catastrophic Coverage** -

After \$4,050 out-of-pocket, you pay the greater of:

- \$2.25 for generic / \$5.60 for other covered drugs or
- 5% coinsurance

**MedicareBlue Rx Option 3**

**Premium** - \$94.00/mo.

**Deductible** - \$0

**Copay/Coinsurance** - (In-network)

- Level 1: Generic \$4
- Level 2: Preferred brand \$37
- Level 3: Brand 50%
- Specialty Drugs 33%

**Coverage Gap** - Level 1: Generic only

**Catastrophic Coverage** -

After \$4,050 out-of-pocket, you pay the greater of:

- \$2.25 for generic / \$5.60 for other covered drugs or
- 5% coinsurance

By joining MedicareBlue Rx Option 3, I attest that I am not receiving any financial support from my current or former employer or union group (or my spouse's current or former employer/union group) intended for the purchase of prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan.

You cannot enroll in MedicareBlue Rx Option 3 if your current or former employer helps pay for your drugs.

**Please mail this form to:**

MedicareBlue Rx  
Customer Service  
P.O. Box 2190  
Chester, VA 23831

## Enrollment Period Determination

Typically, you may only enroll in a Medicare Prescription Drug Plan during the annual open enrollment period between November 15 and December 31 of each year. However, 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 and check one box to the left of the statement. MedicareBlue Rx will contact you for additional information.

- I am enrolling during the annual open enrollment period, November 15 through December 31
- I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums
- I receive extra help paying for Medicare prescription drug coverage as of (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_
- I am no longer eligible for extra help paying for my Medicare prescription drugs as of (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_
- I live in a Long Term Care Facility (for example, a nursing home or long term care facility) as of (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_
- I moved out of a Long Term Care Facility (for example, a nursing home or long term care facility) on (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_
- I belong to a pharmacy assistance program provided by my state
- I am leaving my Medicare Advantage plan within 12 months of my initial enrollment under a Special Enrollment Period to go back to a Medigap plan as of (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_

If none of the statements apply to you or if you are not sure, please call Customer Service at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-800-693-3819), to see if you are eligible to enroll.

## Paying Your Plan Premium

**You can pay your monthly plan premium by mail or by Electronic Funds Transfer (EFT) each month.** After your coverage takes effect, you can also choose to pay your premium by automatic deduction from your Social Security check each month. If you are interested in this payment option, please contact us at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time (TTY/TDD: 1-888-693-3819). 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 does not cover. Generally, you must stay with the option you choose for the rest of this year. If you don't select a payment option, you will receive a bill each month. **Please select a premium payment option (do not send a payment with this application):**

- Receive a paper bill each month
- Electronic Funds Transfer (complete EFT form)\*

\*If you do not have EFT, call Customer Service to receive an EFT form, or visit [www.YourMedicareSolutions.com](http://www.YourMedicareSolutions.com) to download a copy.

I have reviewed the Summary of Benefits before completing this form. I want to transfer from my current plan option to the plan option I have selected here. 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 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 by MedicareBlue Rx or Medicare. I understand that if this form is received by the end of any month, my new plan option will generally be effective the 1st of the following month.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are the authorized representative, you MUST provide the following information:**

Name (Print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Relationship to Enrollee: \_\_\_\_\_



**MedicareBlue<sup>SM</sup> Rx**  
A Medicare Prescription Drug Plan

## **2008 Individual Plan Option Change Form**

Dear MedicareBlue Rx Member:

**Complete this form only if you wish to change your MedicareBlue Rx plan option.**

To change to a different Medicare prescription drug plan option with MedicareBlue Rx, fill out this form by checking the plan option you want and signing the form. Then mail the completed form back to us in the postage-paid envelope.

Generally, you may only change your plan option during the annual enrollment period, between November 15th and December 31st each year, unless you qualify for a special enrollment period (see the Enrollment Period Determination section). For more information about enrollment periods please call Customer Service.

If you select another plan option and we receive your completed form by the end of any month, your new benefit plan will generally begin the first of the following month. Plan premiums are listed on the inside of this form.

Please review the enclosed Summary of Benefits to learn more about the plan options prior to completing the form.

If you have any questions, please call Customer Service at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time. TTY/TDD users should call 1-800-693-3819.

Thank you.

**For More Information...**

Contact your authorized independent agent

Or call MedicareBlue Rx toll-free: 1-888-832-0075

TTY/TDD users should call: 1-800-693-3819

8 a.m. to 8 p.m., daily, Central and Mountain Time

Or visit us on the Web at **[www.YourMedicareSolutions.com](http://www.YourMedicareSolutions.com)**