Welcome to Fallon Medicare Plus™

fallonhealth.org/medicare

Fallon Health – a company that cares

Fallon Medicare Plus™ Premier HMO

Our priority—always—is making sure our members get the care they need and deserve.

Fallon Medicare Plus Premier HMO is Fallon Health's Medicare Advantage plan for retirees.

Plan includes rich benefits like:

Benefit Bank

The Benefit Bank card is preloaded with money that you can use for dental care, eyewear, fitness memberships, and hearing aids. Use the card to pay a portion, or the full cost, of an item. The annual allowance is $250.

Dental

Coverage for preventive care like cleanings, routine exams, and X-rays, as well as comprehensive services like root canals.

Eyewear

$150 toward eyewear, every year.

Hearing aids

Copayments vary from $695 to $2,645 through Amplifon.

SilverSneakers®

Includes a free gym membership and on-demand library of classes, workouts, and instructional videos.

WW® membership

Free 13-consecutive-week WW membership.

Care Connect

24/7 access to registered nurses by phone, at a $0 copay. Nurses provide guidance on where to go for care, and/or they can connect you with your doctor.

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week)

fallonhealth.org/medicare

SilverSneakers® is a registered trademark of Tivity Health, Inc. WW® is a registered trademark of WW International, Inc.

22-686-120 Rev. 00 8/22 H9001_230152_E

Fallon Medicare Plus™ Premier
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 Fallon representative at 1-866-231-3669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week).

Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit fallonhealth.org/medicare or call 1-866-231-3669 (TRS 711) to view or request 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the Formulary to make sure your drugs are covered.

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/coinsurance may change on January 1, 2024.
- ☐ 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).

2023 Fallon Medicare Plus™ Premier HMO Enrollment Form

SECTION 1 – All fields on this page are required *(unless marked optional)*.

To enroll, please provide the following information.

Company name:	Group number:
Authorized signature:	Requested effective date:

Last name: First name: Middle initial: *(optional)*

Birth date: (MM/DD/YYYY) ________ / ________ / ____________

Sex: ❑ M ❑ F

Home phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Mobile phone number: *(optional)* (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

❑ *I authorize Fallon Health to send me text messages related to my plan benefits and services.*

Email address: *(optional)* ____________________

❑ *I authorize Fallon Health to send me email messages related to my plan benefits and services.*

Permanent residence street address (P.O. Box is not allowed):

City/town:	State:	ZIP code:	County: *(optional)*

Mailing address if different from above:

Street address: ____________________

City/town: ____________________ State: ________ ZIP code: ____________

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 the Social Security Administration or the Railroad Retirement Board.

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

Name (as it appears on your Medicare card): ____________________

Medicare number: ____________________

Is entitled to:	Effective date:
❑ Hospital (Part A)	____________
❑ Medical (Part B)	____________

Please read and answer these important questions.

1. **Are you the retiree?** ❑ Yes ❑ No

   If yes, retirement date (month/date/year): ____________________

   If no, name of retiree: ____________________

2. **Are you covering a spouse or dependents under this employer or union plan?** ❑ Yes ❑ No

   If yes, name of spouse: ____________________

   Name(s) of dependent(s): ____________________

Please read and answer these important questions (continued).

3. **Do you or your spouse work?** ❑ Yes ❑ No

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits or State pharmaceutical assistance programs.

   Will you have other *prescription* drug coverage in addition to Fallon Health? ❑ Yes ❑ No

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

   ____

   Name of other coverage: ______________________________

   ID # for coverage: ______________________________

5. **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):

   ____

6. **Please choose a primary care physician (PCP), clinic or health center:**

   ____

Please check the box below if you would prefer us to send you information in another accessible format:

❑ Braille ❑ Audio CD ❑ Large print

Please contact Fallon Health at 1-866-231-3669 (TRS 711) if you need information in an accessible format other than what is listed above.

I want to get the following materials via email. Select one or more.

❑ Evidence of Coverage ❑ Formulary Email address: ______________________________

Please read the important information on the following page and then sign below.

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 by Fallon Health or by Medicare.

X ______________________________ ______________________________

Your signature/authorized representative Today's date

If you are the authorized representative, you must sign above and provide the following information:

______________________________ ______________________________

Name (printed) Relationship to enrollee

____

Address

Phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. 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.*

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ I choose not to answer.

What's your race? *Select all that apply.*

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

SECTION 3 – Read this important information.

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

Fallon Health is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) I can only be in 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. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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.

Fallon Medicare Plus Premier HMO serve a specific service area. If I move out of the area that Fallon Medicare Plus Premier HMO 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 Fallon Medicare Plus Premier HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fallon Medicare Plus Premier HMO when I get it to know which rules I must follow to receive 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.

I understand that beginning on the date Fallon Medicare Plus Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus Premier HMO and other services contained in my plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS PREMIER HMO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Fallon Health, they may be paid based on my enrollment in Fallon Medicare Plus Premier HMO.

Release of information:

By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus Premier HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Medicare Plus Premier HMO will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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.

1-866-231-3669 (TRS 711)

8 a.m.–8 p.m., seven days a week
(Apr.–Sept., 8 a.m.–8 p.m., Mon.–Fri.)

FALLON USE ONLY ❑ New enrollment ❑ Group to group

OEV required: ______ Sales staff initials: ______ OEV complete: ______

Name of staff member (if assisted in enrollment): ______

EGWP: ______ ICEP/IEP: ______ AEP: ______ SEP (type): ______ Not eligible: ______

Staff verification: ______ Effective date of coverage: ______

County code: ______ Previous insurance: ______

Broker name: ______ Broker ID: ______