# 2023 Aetna Medicare Advantage Plan Information

Thank you for your interest in applying for the Aetna Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Aetna within 7 days of the application receipt.

## Enrollment Packet – click links below to view the information

Star Rating: HMO / PPO
Application Downloads: Treasure Valley / Kootenai
Summary of Benefits: Elite Plan (HMO-POS) / Eagle (PPO) / Value Plan (HMO-POS) / Choice Plan 06 (PPO) / Choice Plan 02 (PPO)
Provider Search
Pharmacy Search
Formulary

## Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

## Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

## Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:


CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com


If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://www.medicare-idaho.com

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# Confirm your enrollment period

**Typically, you may enroll in a Medicare Advantage Plan during the Annual Enrollment Period (AEP) 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.

**Read the following statements carefully and check the box if the statement applies to you.** By checking a box you certify 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.

| **Prospective member name** | **Medicare Number** |
|---|---|
| | __ __ __ __ - __ __ __ - __ __ __ __ |

## Reason for Annual Enrollment Period Eligibility

☐ I'm enrolling between 10/15/22-12/7/22 during the current Annual Enrollment Period.

## Reasons for Initial Enrollment Period Eligibility

☐ I'm new to Medicare.

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started.

☐ I had Medicare prior to now, but I'm now turning 65.

## Reasons for Open Enrollment Period Eligibility

**Between 1/1/23 and 3/31/23:**

☐ I'm in a Medicare Advantage plan and want to make a change.

**Between 4/1/23 and 12/31/23:**

☐ I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

## Reasons for Special Enrollment Period Eligibility

☐ I moved to a new address that's outside my current plan's service area, or I recently moved and this plan is a new option for me. I moved on __ __/__ __/__ __ (date).

☐ I was released from jail. I was released on __ __/__ __/__ __ (date).

☐ I moved back to the United States after living outside the country. I returned to the U.S. on __ __/__ __/__ __ (date).

☐ I recently got lawful presence status in the United States. I got this status on __ __/__ __/__ __ (date).

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on __ __/__ __/__ __ (date).

☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on __ __/__ __/__ __ (date).

*(continued on next page)*

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| Prospective member name | Medicare Number |
|---|---|
| | __ __ __ __ - __ __ __ - __ __ __ __ |

**Reasons for Special Enrollment Period Eligibility** *(continued)*

- ☐ I have both Medicare and Medicaid, my state helps pay for my Medicare premiums, or I get Extra Help paying my Medicare drug coverage.
- ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on __ __/__ __/__ __ (date).
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or rehabilitation hospital. I moved out of the facility on __ __/__ __/__ __ (date).
- ☐ I lost other, non-Medicare drug coverage (creditable coverage), or my other non-Medicare coverage changed and is no longer considered creditable coverage. I lost my drug coverage on __ __/__ __/__ __ (date).
- ☐ I left coverage from my employer or union (including COBRA coverage) on __ __/__ __/__ __ (date).
- ☐ I'm in a State Pharmaceutical Assistance Program, or I am losing help from a State Pharmaceutical Assistance Program.
- ☐ I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
- ☐ 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 __ __/__ __/__ __ (date).
- ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the plan on __ __/__ __/__ __ (date).
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state or my local government). One of the other statements applied to me, but I was unable to make my request because of the disaster.

If none of these statements above apply to you, but you feel you have a special circumstance which allows you to enroll, you can call us at **1-833-859-6031 (TTY: 711)**. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. We can help you to determine if you qualify for a Special Election Period.

Otherwise, note the reason for your Special Election period below. Aetna may contact you to determine if you're eligible.

☐ Other SEP Reason: _____

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**Enrollment Request Form**

| **Agent Use Only:** |
|---|
| Agent Name: |
| NPN#: |

**To enroll in an Aetna plan, please provide the following information:**

## Choose your plan

**Check the plan you want to enroll in.**

| | |
|---|---|
| ☐ Aetna Medicare Choice Plan (PPO) (H9431-002) | **$36.00** per month |
| ☐ Aetna Medicare Eagle Plan (PPO) (H9431-016) | **$0.00** per month |

*Note: Plans with an asterisk ( * ) next to the plan name must have a Primary Care Provider (PCP) assigned. See the **Choose your Primary Care Provider (PCP)** information below.*

**Proposed Effective Date of Coverage:** __ __ / __ __ / __ __
Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1. Aetna cannot guarantee the effective date you've requested will be honored.

## Choose your Primary Care Provider (PCP)

Some of our plans coordinate your care through a PCP. We have noted these plans with an asterisk ( * ) next to the plan name (*Example: "*Aetna Prime Plan (HMO)"*). If you selected a plan noted with an asterisk, and do not choose a PCP, we may not pay for your care and will assign a PCP to you. **Please note that a specialist is not considered a valid PCP selection.**

If the plan you have selected does NOT have an asterisk ( * ) next to the plan name, you still have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Write in the **name, Provider ID** and **Primary Care ID** of your primary care provider (PCP) below. Visit our online provider directory at **AetnaMedicare.com/findprovider** or call **1-833-859-6031 (TTY: 711)** to find provider information or a network PCP for your specific plan selection.

| | |
|---|---|
| **Full name of your PCP** (first and last name) | **Are you a current patient?** ☐ Yes ☐ No |
| **Provider ID** (located in the provider directory) | ☐☐☐☐☐☐☐ |
| **Primary Care ID** (located in the provider directory) | ☐☐☐☐☐☐ |

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# Your information

**Last name** | **First Name** | **Middle initial**

**Birth date**
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

**Sex**
☐ M
☐ F

**Phone number:** ( _ _ _ ) _ _ _ - _ _ _ _
Is this a mobile number? ☐ Yes ☐ No

**Email address**

**Permanent residence street address - including Apt/Suite/Unit** (a PO Box is not allowed)

**City** | **County** | **State** | **ZIP code**

**Mailing address - including Apt/Suite/Unit** (if different from your permanent street address)

**City** | **State** | **ZIP code**

## Your Medicare information

This information is on your red, white and blue Medicare insurance card
You must have Medicare Part A and Part B to join a Medicare Advantage plan.

**Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _

Effective Date:

**HOSPITAL (Part A)** _ _ / _ _ / _ _ _ _

**MEDICAL (Part B)** _ _ / _ _ / _ _ _ _

## Answer these important questions

☐ Yes ☐ No

1. **Will you have other prescription drug coverage in addition to Aetna Medicare?** Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. 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: _____

☐ Yes ☐ No

2. **Are you enrolled in your state's Medicaid program?**

If "Yes," write in your Medicaid number: _____

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# Please tell us a little more about yourself

**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.**

Indicate your **preferred spoken language** (if not English):

☐ Spanish ☐ Other (please specify):

Indicate your **preferred written language** (if not English):

☐ Spanish ☐ Other (please specify):

If you need information in another language or accessible format (for example, large print or braille), contact us at **1-833-859-6031 (TTY: 711)**, 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

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# Plan premium and/or late enrollment penalty (LEP) payment

Let us know how you want to pay your monthly plan premium (including any late enrollment penalty you may owe). Please select an option even if your plan has a $0 premium. If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer (EFT) from checking or savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.

**Please complete the following:**

Account holder name: _____

(Print the name as it appears on the account to be debited.)

Bank name: _____

ROUTING NUMBER ☐☐☐☐☐☐☐☐☐

ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ☐ Checking ☐ Savings

Signature of account holder: (if different than enrollee) _____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) check.**

**I get monthly benefits from:** ☐ **Social Security** ☐ **RRB**

- **Do not select this option if:**
  - Another program (such as an Employer Group or State Pharmaceutical Assistance Program (SPAP) is paying part of your premium.
  - You are enrolling in a plan with a $0 premium and you do not owe a late enrollment penalty.
  - You are enrolling in a Dual-Eligible Special Needs Plan (DSNP) or an Institutional Special Needs Plan (ISNP).
- SSA or RRB will tell us when your premium deduction will start coming out of your SSA/RRB check. You'll need to pay your premiums directly to us for any months the SSA/RRB doesn't cover. We'll send you an invoice for the months SSA/RRB doesn't cover.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRB check. If they don't accept the deduction request, we'll send you an invoice to pay your monthly premium.

☐ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can go online and pay by debit or credit card after your enrollment in the plan is active.
- You can bring your invoice to any retail CVS Pharmacy® and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy Target® or Schnucks Pharmacy locations.)

*(continued)*

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# Plan premium and/or late enrollment penalty (LEP) payment

## Additional notes about payment and options

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your SSA or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D IRMAA payment to us**.
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your SSA or RRB benefit check.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. 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 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 **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp**.
- If you qualify for Extra Help with your Medicare prescription drug 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.

# Read this important information and sign below

- **If you currently have health coverage from an employer or union, joining Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Aetna Medicare**. 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.
- I must keep both Hospital (Part A) and Medical (Part B) to stay in Aetna Medicare.
- By joining this Medicare Advantage plan, I acknowledge that Aetna Medicare 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).

### PRIVACY ACT STATEMENT

- The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.
- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-For-Service (PFFS), MA Medical Savings Account (MSA) plans).
- **MA-only plans:** I understand that when my Aetna Medicare coverage begins, I must get all of my medical benefits from Aetna Medicare. **MA-PD plans:** I understand that when my Aetna Medicare

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coverage begins, I must get all of my medical and prescription drug benefits from Aetna Medicare. **All plans:** Benefits and services provided by Aetna Medicare and contained in my Aetna Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Aetna Medicare will pay for benefits or services that are not covered.

- 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 legally 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.

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area.

| **Signature** | **Today's date**<br>__ __/__ __/__ __ __ __ |
|---|---|

If you're an authorized representative helping someone fill out this form, you must sign above and provide the following information.

| Name | Address |
|---|---|
| Phone number<br>(__ __ __) __ __ __ - __ __ __ __ | Relationship to enrollee |

According to the Paperwork Reduction Act (PRA) of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**IMPORTANT:** Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to Enroll" on the first page of this form to send your completed form to the plan.

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# AGENT USE ONLY

## Agent/producer/broker/representative must complete this section

Applicant's name

**If you are the agent/producer/broker/employed sales representative, you must provide the following information and submit it with the completed application.**

| | |
|---|---|
| ☐ Yes ☐ No | Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.)<br><br>If "No," why not? : _____ |
| ☐ Yes ☐ No | Was the SOA captured electronically or by telephone?<br><br>If "Yes," please provide the confirmation/ID number: _____<br><br>Attach the SOA or indicate why it's not available: _____ |

Name of agent/producer/broker/sales rep: Tiffany Jackson

| | |
|---|---|
| Phone number: 541-434-9613 | National Producer Number (NPN): 14254716 |

☐ Check box if application received at a retail kiosk.

**NOTE: If the agent/producer/broker/employed sales representative takes receipt of this application, a signature and date are REQUIRED below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.**

| | |
|---|---|
| Signature of agent/producer/broker/sales rep: | Date agent received the Individual Enrollment Request Form: |

**Copy and keep this completed form for your records. The completed election period checklist on page 1 must be included with the form.**

Fax or mail the completed form to:
**Aetna Medicare**
**PO Box 7405 London, KY 40742**
**Fax: 1-866-756-5514**

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MM/DD/HH

Use scissors to easily remove this page.

# Scope of Sales Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

**Please initial below beside the type of product(s) you want the agent to discuss.**
(Refer to page 2 for product type descriptions.)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Supplemental Health Products**
- ☐ **Medicare Supplement (Medigap) Products**

**By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.** Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

| **Beneficiary or Authorized Representative Signature and Signature Date:** | |
|---|---|
| Signature: | Signature Date: |
| **If you are the authorized representative, please sign above and print below:** | |
| Representative's Name: | Your Relationship to the Beneficiary: |
| **To be completed by Agent:** | |
| Agent Name: Tiffany Jackson | Agent Phone: 541-434-9613 |
| Beneficiary Name: | Beneficiary Phone: |
| Beneficiary Address: | |
| Initial Method of Contact: (Indicate here if beneficiary was a walk-in.) | |
| Agent's Signature: | |
| Plan(s) the agent represented during this meeting: | Date Appointment Completed: |
| **Plan use only** | |
| Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: | |

Scope of Appointment documentation is subject to CMS record retention requirements.

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