Blue Medicare HMO℠

MedicareRx
Prescription Drug Coverage

BlueCross BlueShield of North Carolina
P.O. Box 25190
Durham, NC 27702

2025 Plan Change Form for Medicare Advantage HMO Plan

Individuals experiencing homelessness:

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

A. Personal Information (exactly as it appears on your Medicare card):

First Name: Middle Initial:

Last Name: Suffix:

Blue Cross NC Member Number: - Medicare Number:

Primary Phone Number: - - Alternate Phone Number: (optional) - -

Email Address: (optional)

Permanent Residence Street Address:

City: State: Zip Code:

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

City: State: Zip Code:

B. 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; another Hispanic, Latino(a), or Spanish origin
- ☐ Yes; Puerto Rican
- ☐ Yes; Cuban
- ☐ **I choose not to answer.**

What is 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 Hawaii
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

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

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

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

C. Communication Preferences:

Please contact Blue Cross and Blue Shield of North Carolina (Blue Cross NC) if you need information in an alternative language, such as Spanish at 1-800-665-8037 (TTY: 711). Our office hours are 7 days a week, 8 a.m. to 8 p.m.

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

- ☐ Braille
- ☐ Large print
- ☐ Audio CD
- ☐ Data CD (Flash drive)

I want to get Plan Materials via email. I have provided my email address above. Once a member, please visit **BlueConnectNC.com** to set your communications preferences.

☐ Yes ☐ No

D. Please complete the following:

I am **currently** a member of the Blue Medicare HMO:

☐ Medical Only	H3449-012	$ 0.00
☐ Experience Health	H3777-001-002	$ 0.00
☐ Experience Health	H3777-001-003	$ 0.00
☐ Experience Health	H3777-001-004	$ 0.00
☐ Essential	H3449-027-001	$ 0.00
☐ Essential	H3449-027-002	$ 0.00
☐ Essential Plus	H3449-023-001	$ 0.00
☐ Essential Plus	H3449-023-002	$ 0.00
☐ Essential Plus	H3449-023-004	$ 0.00
☐ Essential Plus	H3449-023-005	$ 0.00
☐ Choice	H3449-026	$ 0.00
☐ Enhanced	H3449-024-001	$ 19.00
☐ Enhanced	H3449-024-002	$ 34.00
☐ Enhanced	H3449-024-003	$ 45.00

Note: These are 2024 rates.

I would like to **change** to the Blue Medicare:

☐ Medical Only	H3449-012	$ 0.00
☐ Experience Health	H3777-001-002	$ 25.00
☐ Experience Health	H3777-001-003	$ 25.00
☐ Experience Health	H3777-001-004	$ 25.00
☐ Essential	H3449-027-001	$ 0.00
☐ Essential	H3449-027-002	$ 0.00
☐ Essential Plus	H3449-023-001	$ 0.00
☐ Essential Plus	H3449-023-002	$ 0.00
☐ Essential Plus	H3449-023-004	$ 0.00
☐ Essential Plus	H3449-023-005	$ 0.00
☐ Choice	H3449-026	$ 0.00
☐ Enhanced	H3449-024-001	$ 19.00
☐ Enhanced	H3449-024-002	$ 34.00
☐ Enhanced	H3449-024-003	$ 40.00

Note: These are 2025 rates.

I understand that this plan has different health benefits and a different monthly premium.

E. Your Plan Premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail 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.

Zero Premium Plans: 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 each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

Plans with premiums: 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 benefit check each month.

Continued ▶

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 Railroad Retirement Board. Do NOT pay Blue Cross NC 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 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance.

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 users should call **1-800-325-0778**. You can also apply for *Extra Help* online at ***ssa.gov/PrescriptionHelp***. 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. You must continue to pay your Medicare Part B premium.

Please select a premium payment option:

☐ Keep current payment method.

☐ Get a bill each month.

☐ Automatic deduction from your monthly Social Security benefit check.

☐ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

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, 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.

F. Please read and sign below:

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Blue Cross and Blue Shield of North Carolina (Blue Cross NC), he/she may be paid based on my enrollment in Blue Cross NC.

I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in my current Medicare Advantage and/ or Prescription Drug plan.

1. I must keep both Hospital (Part A) and Medical (Part B) to stay in Blue Medicare HMO.
2. I understand that beginning on the date Blue Medicare HMO coverage begins, I must get all of my health care from Blue Cross NC participating providers except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Cross NC and other services contained in my Blue Medicare HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor Blue Cross NC will pay for the services**.

G. Release of Information:

By joining this Medicare health plan, I acknowledge that Blue Cross NC will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Blue Cross NC 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.

H. Applicant Agreement:

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,** 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.

Your Signature: _____ Today's Date: ☐☐ / ☐☐ / ☐☐☐☐
(mm/dd/yyyy)

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

Name:

Address:

City: State: Zip Code:

Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Relationship to Enrollee:

I. 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: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number: _____
(Agents / Brokers only)

Continued ▶

LICENSED AGENT USE ONLY

Agents must submit a signed enrollment form within 24 hours of receipt.

Agent's Signature: _____ Print Agent's Name: _____

Date Application Received: ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

NPN#: _____ Required

Phone Number: _____ Agent Number: _____

Blue Cross and Blue Shield of North Carolina is an HMO, HMO-POS plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Experience Health Medicare Advantage (HMO) depends on contract renewal.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.

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BlueMedicare HMO℠

BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-310-4110 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llámenos al 1-888-310-4110 (TTY: 711). Alguien que hable inglés le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的口译服务，帮助您解答关于我们健康或药物计划的任何疑问。要获得口译员服务，请致电 1-888-310-4110 (TTY: 711)。会有讲英文/中文的工作人员帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康保險或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-310-4110 (TTY: 711) 聯絡我們。我們講英語/您的語言的人員將樂意為您提供幫助。這項服務是免費的。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-310-4110 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng English o Tagalog. Ito ay libreng serbisyo.

French: Nous fournissons gratuitement les services d'un interprète pour répondre à toutes les questions que vous pouvez avoir sur notre régime d'assurance maladie ou de médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-310-4110 (TTY: 711). Un interlocuteur qui parle anglais/français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về kế hoạch sức khỏe hoặc thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-310-4110 (TTY: 711) sẽ có nhân viên nói tiếng Anh/Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Die Dolmetscher erreichen Sie unter 1-888-310-4110 (TTY: 711). Man wird Ihnen dort auf Deutsch oder Englisch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 처방약 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-310-4110 (TTY: 711) 번으로 문의해 주십시오. 영어/한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно плана медицинского страхования или плана получения лекарств, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону1-888-310-4110 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-английски или на вашем языке. Данная услуга бесплатная.

Arabic: يمكننا تقديم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلةتتعلق بخطة الصحة أو الأدوية الخاصة بنا. وللحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على رقم 1-888-310-4110 (TTY: 711) . وسوف يساعدك شخص يتحدث اللغة الإنجليزية / العربية. هذه خدمة مجانية.

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BlueMedicare HMO℠

BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

Hindi: हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का जवाब देने के लिए हमारे पास मुफ्त में दुभाषिया सेवाएँ उपलब्ध है. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-310-4110 (TTY: 711) पर फोन करें. अंग्रेजी/हिन्दी बोलने वाला व्यक्ति आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-310-4110 (TTY: 711). Un nostro incaricato che parla inglese/italiano vi fornirà l'assistenza necessaria. Il servizio è gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que você tiver acerca de nosso plano de saúde ou de medicação. Para obter um intérprete, contate-nos pelo número 1-888-310-4110 (TTY: 711). Você encontrará alguém que fale o idioma inglês ou português para ajudá-lo. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan asirans maladi oswa asirans medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-310-4110 (TTY: 711). Yon moun ki pale Anglè/Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza należy zadzwonić pod numer 1-888-310-4110 (TTY: 711). Osoba znająca polski i angielski udzieli Państwu pomocy. Usługa ta jest bezpłatna.

Japanese: 弊社の健康保険または処方薬保険に関するあらゆるご質問にお答えするために、無料の通訳サービスをご用意しております。通訳をご希望の場合は、1-888-310-4110 (TTY: 711) までお電話ください。日本語または英語を話す担当の者が支援いたします。これは無料のサービスです。

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Form CMS-10802 (Expires 12/31/25)