# Instructions for Participants with Medicare to Complete the Application to Re-enroll in TRS-Care

During the 2018 TRS-Care Grace Period through Feb. 28, 2018

Please complete a separate 700GPM application and TRS-Care Medicare Rx enrollment form for **each person with Medicare** (the retiree and any eligible dependents) that wishes to re-enroll in TRS-Care.*

Please take the following steps for each person with Medicare that is re-enrolling in TRS-Care:

- Complete the 700GPM application (pages 1 through 3 in this packet),
- Complete the TRS-Care Medicare Rx Employer PDP sponsored by TRS (TRS-Care Medicare Rx) Medicare Part D Enrollment Form (pages 4 and 5 in this packet), and
- Sign both.
- Please fax all pages back to TRS at (512) 542-6575 or mail all pages to TRS at the address on the application. The application must be post-marked no later than February 28, 2018. Your coverage will be effective the first day of the month following the time we receive your application.

Important Information

If you choose to re-enroll in TRS-Care, you will be reinstated in the coverage you would have had on Jan. 1, 2018, had you not terminated TRS-Care. This is not an opportunity to add new dependents. You can only reinstate participants that were previously covered under TRS-Care and were terminated from TRS-Care coverage between July 1, 2017 and January 1, 2018.

## Notice to participants who opted out of TRS-Care Medicare drug coverage prior to terminating:

TRS is only reinstating the coverage you had prior to Jan. 1, 2018. Therefore, if you did not have Medicare prescription drug coverage as of the date you terminated TRS-Care, you will not be enrolled in TRS-Care Medicare Rx prescription drug coverage.

If this applies to you, you do not need to complete the TRS-Care Medicare Rx Enrollment Form (pages 4 and 5 of this packet).

If you do complete these pages, TRS will disregard this portion of the application and reinstate you in the TRS-Care Medicare Advantage plan only.

**If you have questions about how to complete the application, please contact TRS Health & Insurance Benefits at 1-888-237-6762.**

*If anyone covered by the plan does not have Medicare, you will need to complete the 700GP application for those enrollees. You can find that application on the TRS website at www.trs.texas.gov/Pages/healthcare_trscare_grace_period.aspx.

TRS 700GPM
Rev. 01-18

TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red River Street, Austin, Texas 78701-2698
Telephone 1 (888) 237-6762
www.trs.texas.gov

# TRS-CARE MEDICARE ADVANTAGE PLAN GRACE PERIOD RE-ENROLLMENT APPLICATION

| EFFECTIVE DATE |
|---|
| First of the month following receipt by TRS of your application to re-enroll |

Name: _____ Primary Phone #: _____

Address: _____ E-mail Address: _____

SSN: _____ Date of Birth: _____

Please provide your physical residential address if the mailing address above is a PO Box.

_____
Street Address City State Zip Code

**SECTION A** **Please check the box below if you want to re-enroll in the TRS-Care Medicare Advantage Medical Plan.**

☐ **TRS-CARE MEDICARE ADVANTAGE MEDICAL PLAN**
*You must have Medicare Part B to be eligible for this plan*

**SECTION B** **Please use your current red, white, and blue Medicare card to complete this section.**

Medicare Claim #: _____

Medicare A effective date: _____ Medicare B effective date: _____

☐ Yes ☐ No Do you have Medicare due to End Stage Renal Disease?

*If Yes,* give first date of dialysis: _____

**SECTION C** **Acknowledgement and Acceptance**

I certify that the information on this form is true and complete to the best of my knowledge. I understand that giving false information on this form may result in loss of coverage.

I acknowledge that my confidential information may be disclosed to third parties that assist TRS in connection with the administration of the health plan in which I am enrolled.

Information collected on this form includes my telephone number and my cell phone number, if provided. I understand that this information will also be provided to third parties in connection with health plan administration. I consent to calls or texts at these numbers and I understand that the calls I receive could be automated. **I understand that I can cancel this consent to receiving calls and texts at these numbers at any time** without affecting my eligibility for benefits, enrollment and coverage, and without affecting my ability to get treatment. Upon request, TRS will provide me the identity of the third parties that may be communicating with me at these phone numbers and I may contact those third parties directly regarding the use of my phone numbers. I also understand that data use charges and rates from my cellular carrier may apply.

I authorize the Teacher Retirement System (TRS) to withhold from my monthly annuity and remit to TRS-Care any amount necessary to cover my share of the cost of the selected coverage. If the amount of my annuity is not sufficient to cover the cost of the selected coverage, or if I am not receiving a monthly annuity, I understand that TRS-Care or the TRS-Care administrator will bill me, and I understand that it is my responsibility to send payment on a timely basis. I understand that failure to pay my full premium amount timely may result in termination of my coverage and termination of coverage for any of my eligible dependents.

Please note that future plan options may change.

_____ _____
Signature Date

| SECTION D | **TRS-Care Medicare Advantage Acknowledgement Form**<br>*(The following information must be completed and signed.)* |
|---|---|
| **Name:** | **Medicare Claim # :** |

**DISCLOSURES – Read this section carefully**

**By completing this enrollment application, I agree to the following:** The TRS-Care Medicare Advantage Preferred Provider Organization (PPO) with an Extended Service Area (ESA) Plan for TRS-Care is a Medicare Advantage contract with the Federal government. I will need to keep my Medicare Part B in effect. 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. If I am enrolling in the Medicare Advantage plan without prescription drug coverage (medical benefits only), 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 a Medicare prescription drug plan in the future. I understand that the TRS-Care Medicare Prescription Drug Plan is considered creditable coverage under Medicare. Creditable coverage means that on average, TRS-Care prescription coverage is equal to or better than the Medicare Part D coverage provided directly from Medicare. Having creditable coverage allows me to enroll in a Medicare Part D plan during future annual Medicare Part D plan enrollments without a penalty (higher premium) from Medicare.

Enrollment in this TRS-Care Medicare Advantage PPO ESA plan is generally for the entire year. However, once I enroll, I may leave this plan at any time.

The TRS-Care Medicare Advantage PPO ESA plan services a specific service area. If I move out of the TRS-Care Medicare Advantage PPO ESA plan service area, I need to notify TRS-Care. Once I am a participant of the TRS-Care Medicare Advantage PPO ESA plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Humana when I get it to know which rules I must follow to get coverage with this TRS-Care Medicare Advantage PPO ESA plan. I understand that people with Original Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with Federal requirements.

**TRS-Care Medicare Advantage PPO ESA plan:** I understand that beginning on the date TRS-Care Medicare Advantage PPO ESA plan 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. I understand that I can go to doctors, specialists, or hospitals in or out-of-network. I understand that providers must be licensed and eligible to receive payment under the Federal Medicare program and agree to accept the TRS-Care Medicare Advantage PPO ESA plan. I also understand that I may have to pay more for services that I receive out-of-network when the provider is not licensed and not eligible to receive payment under the Federal Medicare program. Services authorized by the TRS-Care Medicare Advantage PPO ESA plan and other services contained in my TRS-Care Medicare Advantage PPO ESA plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, when required by Humana, **NEITHER MEDICARE NOR THE TRS-CARE MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.**

I have been advised not to cancel or terminate any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Humana.

I understand that the providers in the Humana network are independent contractors in private practice and are neither employees nor agents of Humana or its affiliates.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Humana's Medicare Advantage plan, he/she may be paid based on my enrollment in the Medicare Advantage plan.

**Release of information:** By joining this TRS-Care Medicare Advantage PPO ESA health plan, I acknowledge that Humana or its affiliates will release my information to Medicare and others as is necessary for treatment, payment of claims and health care operations. I also acknowledge that TRS-Care Medicare Advantage PPO ESA 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, this 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.

**Long Term Care Facility**

Are you a resident in a long-term care facility, such as a nursing home?

☐ Yes ☐ No

*If Yes*, provide the following information:

Name of Institution: _____ Phone number: _____

Address: _____ State: _____ ZIP: _____

**End Stage Renal Disease**

Do you have Medicare due to End Stage Renal Disease?

☐ Yes Proceed below ☐ No Proceed to the question about Medicaid

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, 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.

*If Yes*, what is the date of your first dialysis treatment?

Date: (Month) _____ (year) _____

Do you have Medicare because of End Stage Renal Disease and has it been less than 30 months since you became eligible?

☐ Yes ☐ No

*If Yes*, please provide prior commercial coverage: Carrier's name _____

Member number: _____ Effective date: _____

**Medicaid Program**

Are you enrolled in your state Medicaid program (different than Medicare)?

☐ Yes ☐ No

*If Yes*, provide your Medicaid ID number: _____

| **Signature of Retiree, Spouse, or Dependent Child (if 18 or older) or Authorized Representative:** | **Date:** |
|---|---|

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

| **Representative's name:** | **Address:** |
|---|---|
| **Phone number:** | **Relationship to enrollee:** |

TRS-Care Medicare Advantage PPO is a Medicare Advantage plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. This information is not a complete description of benefits. Contact Humana at 1 (800) 320-9566 for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. You must continue to pay your Medicare Part B premium.

**Make a copy for your record and return to the address below:**

TRS Health & Insurance Benefits
Teacher Retirement System of Texas
1000 Red River Street, Austin, Texas 78701-2698
Telephone 1 (888) 237-6762
Fax (512) 542-6575
www.trs.texas.gov

**2018 SilverScript® Insurance Company**

**TRS-Care Medicare Rx Employer PDP sponsored by TRS (TRS-Care Medicare Rx)**
**Medicare Part D Enrollment Form**

## Please Read This Important Information

**Reasons for Special Enrollment Period Eligibility:** I received a notice from the Plan that I am eligible.

**Please check the SilverScript plan in which you wish to enroll.** ☐ **T**RS-Care Medicare Rx

## Paying Your Plan Premium

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, TRS-Care will bill you for the amount that Medicare does not cover.

## Please Read and Answer These Important Questions

Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

Do you have other prescription drug coverage in addition to SilverScript? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage. The shaded line shows how this may appear on your card.

| Plan Name | Effective Date | Term Date | RxBin | RxPCN | RxGroup | RxID# |
|---|---|---|---|---|---|---|
| ABC Insurance | 10/01/2008 | 12/31/2013 | 123456 | 0049876912 | ABC1234 | 123456789 |
| | | | | | | |
| | | | | | | |

Since you became eligible for Medicare, have you had any prescription drug coverage or any insurance that included drugs? ☐ Yes ☐ No

If you answer no, your premium may be increased because of a late enrollment penalty. If you answer yes, we may ask you for proof that your previous prescription drug coverage was at least as good as Medicare's standards prescription drug coverage (creditable prescription drug coverage). You can send copies of your proof with this form or you can wait until we ask for it. You don't have to send your proof to enroll. However, if we ask you for your proof and you don't provide it, your premium may be increased because of a late enrollment penalty. For more information about the late enrollment penalty, visit www.Medicare.gov or call 1-800-MEDICARE.

## STOP! Please Read This Important Information STOP!

**If you are a member of a Medicare Advantage Plan that is NOT sponsored by TRS-Care** (such as an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining SilverScript, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

**If you currently have health coverage from another employer or union, joining TRS-Care Medicare Rx Employer PDP sponsored by TRS (TRS-Care Medicare Rx) could affect your other employer or union health benefits.** You could lose your employer or union health coverage if you join SilverScript. 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 information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Please Read Terms and Sign on Page 5**

**By completing this enrollment form, I agree to the following:**
SilverScript Employer PDP is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform SilverScript of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in SilverScript will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, unless I qualify for certain special circumstances.

SilverScript serves a specific service area. If I move out of the area that SilverScript 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 SilverScript, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from SilverScript when I get it to know which rules I must follow to get coverage.

**Release of Information**
By joining this Medicare Prescription Drug Plan, I acknowledge that SilverScript will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations 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 state law 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 Medicare.

**Applicant's or Authorized Representative's Signature**

**Your Signature** **Today's Date**

**Print Name** *(please print)*

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

**Power of Attorney / Authorized Representative**

If you are an authorized representative, you must provide the following information (not for agent use)

**Name** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

**Address** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

**City** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ **State** __ __ **ZIP Code** __ __ __ __ __

**Phone Number** __ __ __ — __ __ __ — __ __ __ __

**Relationship to Enrollee** ☐ Child ☐ Friend ☐ Spouse ☐ Other

☐ Please check if authorized representative should receive duplicate copy of plan materials.

When you've completed your Enrollment Form, make a copy for your record and return to the address below using proper postage:

**TRS Health & Insurance Benefits, Teacher Retirement System of Texas**
**1000 Red River Street, Austin, Texas 78701-2698**

**Telephone 1 (888) 237-6762, Fax (512) 542-6575, www.trs.texas.gov**

You must continue to pay your Medicare Part B premium.

TRS-Care Medicare Rx Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

PLEASE RETURN TO TRS