

2027 Enrollment Form

True West Rx 4 (PPO)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare ID number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall Annual Enrollment Period (October 15 – December 7), the plan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium—you can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Range Health
P.O. Box 9018, Boise, ID 83707-9018

Or enroll online at **rangehealth.com**.

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Range Health, Inc. at 1-844-419-2760. TTY users can call 711. Our hours are 8 a.m. to 8 p.m., from October 1 to March 31 and Monday through Friday from April 1 to September 30.

Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, seven days a week.

En español: Llame a Range Health, Inc. al 1-833-574-6031 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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.

According to the Paperwork Reduction Act 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 "What happens next?" on the previous page to send your completed form to the plan.

CONFIRM THE PLAN YOU ARE APPLYING FOR BY CHECKING THE BOX BELOW:

☐ True West Rx 4 (PPO) \$139

Available in the following counties in Idaho: Kootenai.

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

PLEASE PROVIDE YOUR INFORMATION:

First Name	Last Name	M.I. (optional)	Sex: ☐ Male ☐ Female
Birth Date (MM/DD/YYYY)	Phone ()	Mobile Phone* ()	
Email Address* ☐ I want to get plan materials via email		County (optional)	

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

Address	City	State	Zip Code
Mailing address, if different from your permanent address (P.O. Box allowed):			
Address	City	State	Zip Code

*OPTIONAL: By providing us with your email address or mobile phone number you are agreeing to receive communications regarding your plan benefits and well-being. You can opt out at any time.

YOUR MEDICARE INFORMATION:

Medicare ID Number: _____ - _____ - _____

Medicare Beneficiary Identifier (MBI)

ANSWER THIS IMPORTANT QUESTION:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Range Health, Inc.? ☐ Yes ☐ No

Name of other Coverage: _____ Member Number for this Coverage: _____ Group Number for this Coverage: _____

Dates of other coverage:
Start date (MM/DD/YYYY): _____ End date (MM/DD/YYYY): _____

PLEASE CONFIRM YOUR ELIGIBILITY FOR ENROLLMENT:

Typically, you may enroll in a Medicare Advantage plan only 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.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying 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. If none of these statements applies to you or you're not sure, you can speak with an enrollment expert at 1-844-419-2760 (TTY 711) 8 a.m. to 6 p.m. Monday to Friday to see if you are eligible to enroll.

- ☐ I am enrolling during the Annual Enrollment Period (AEP) October 15 – December 7.
- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) January 1- March 31.
- ☐ I am in a Medicare Advantage Plan and have had Medicare for less than 3 months. I want to make a change.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved or will move on (insert date) _____.
- ☐ I recently was released from incarceration. I was or will be released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I moved or will move back to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got or will get this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid). This change happened on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help). This change happened on (insert date) _____.
- ☐ I'm in a State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ I recently moved out of a long-term care facility within the last two months (for example, a nursing home or a rehabilitation hospital). I moved on (insert date) _____.
- ☐ I moved into or I already live in a long term care facility (for example, a nursing home or rehabilitation hospital).
- ☐ I am new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified of getting Medicare on (insert date) _____.
- ☐ I have had Medicare prior to now, but I am now turning 65.
- ☐ I left coverage from my employer or union (including COBRA coverage). I left or will leave on (insert date) _____.

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- ☐ I lost other, non-Medicare prescription drug coverage that's as good as Medicare prescription drug coverage (creditable coverage), or my other, non-Medicare prescription drug coverage changed and is no longer considered creditable. This happened on (insert date) _____.
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. This change happened on (insert date) _____.
- ☐ I lost my coverage because Medicare ended its contract with my plan. I received a letter from Medicare saying I can join another plan. My plan ended on or will end on (insert date) _____.
- ☐ I lost my coverage because my plan no longer covers the area that I live or it ended its contract with Medicare.
- ☐ I recently left a PACE (Programs of All-Inclusive Care for the Elderly) program. I dropped my coverage on (insert date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. That plan started on (insert date) _____.
- ☐ I am in a plan that has had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- ☐ I am in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
- ☐ I was affected by an emergency or a disaster (as declared by the Federal Emergency Management Agency, or by federal, my state, or my local government). One of the other statements on this page applied to me, but I was unable to make my request because of the disaster.
- ☐ I requested plan materials in an accessible format and was not given equal time to make an enrollment decision.
- ☐ Other _____

Section 2 – All fields on this page are optional

**ANSWERING THESE QUESTIONS IS YOUR CHOICE.
YOU CAN'T BE DENIED COVERAGE BECAUSE YOU DON'T FILL THEM OUT.**

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact a customer advocate at 1-833-574-6031 (TTY: 711) if you need information in an accessible format or language other than what is listed above.

We are available seven days a week from 8 a.m. to 8 p.m., October 1 to March 31 and 8 a.m. to 8 p.m. Monday through Friday April 1 to September 30.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Please choose a PCP from your plan's True West (PPO) Provider Network.

Visit rangehealth.com/findadoctor for a list of participating network providers. Enter the PCP ID number below exactly as it appears on the website or in the Provider Directory. It will be a 14-digit PCP ID: Example: ST000000001005.

Name of Primary Care Provider (PCP): _____

PCP ID Number: _____ Are you an existing patient? ☐ Yes ☐ No

If you do not specify a PCP, one will be assigned for you.

Are you a veteran of the U.S. Armed Forces? ☐ Yes ☐ No

Requested Service Effective Date: _____

PLEASE SELECT A PREMIUM PAYMENT OPTION:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by choosing one of the following options.

If you don't select an option below, we will keep your current billing option in place, or send you a monthly bill.

- ☐ **Automatic deduction from monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. **You are responsible for paying your premium until we notify you of your start date.** 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 that 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.

I get monthly benefits from: ☐ Social Security ☐ RRB

- ☐ **Monthly bill**

- ☐ **Automatic deduction from your bank account – automated clearing house (ACH)**

We automatically deduct your payment on the 5th of each month.

Account Holder Name: _____

Routing Number: _____ Account Number: _____

Account Holder Signature(s): _____

If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay Range Health, Inc. the Part D IRMAA.

IMPORTANT – READ AND SIGN BELOW:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Range Health, Inc.
- By joining this Medicare Advantage Plan, I acknowledge that Range Health, Inc. will share my information with Medicare, who may use it to track my enrollment, to make payment, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below). 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 PFFS, MA MSA plans).
- I understand that when my Range Health, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Range Health, Inc. Benefits and services provided by Range Health, Inc. and contained in Range Health, Inc. Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Range Health, Inc. 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) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 1. This person is authorized under state law to complete this enrollment.
 2. Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's Date:** _____

If you're the authorized representative, sign above and complete the fields below.

Name: _____ **Relationship to Enrollee:** _____

Address: _____

Phone Number: (____) _____

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): _____

If applicable, please attach a power of attorney form.

FOR OFFICE OR AGENT USE ONLY:

Name of Agent/Broker (if assisted in enrollment): _____

Range Health Broker ID: _____

Date Enrollment Form Taken by Agent: _____

Enrollment was performed via ☐ Telephone/Teleconference ☐ In person

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.

2027 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 customer service representative toll-free at 1-833-574-6031 (TTY: 711), 8 a.m. to 8 p.m., from October 1 to March 31 and Monday through Friday from April 1 to September 30.

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 rangehealth.com/MemberResources to view or call 1-833-574-6031 (TTY: 711) to 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, 2028.

☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by noncontracted providers.

☐ Effect on current coverage: if you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

DISCRIMINATION IS AGAINST THE LAW

Range Health complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Range Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Range Health Civil Rights Coordinator at 1-833-574-6031 (TTY: 711).

If you believe that Range Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator

3000 E. Pine Ave., Meridian, ID 83642

Telephone: 1-833-865-3453

Fax: 208-387-6690

Email: CivilRightsCoordinator@rangehealth.com

TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

ATTENTION: If you speak Arabic, Bosnian, Chinese, French, German, Italian, Japanese, Korean, Nepali, Portuguese, Russian, Spanish, Swahili, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-833-574-6031 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجاناً اتصل على 1-833-574-6031 (للصم والبكم: 711).

Bosnian: PAŽNJA: Ako govorite bosanski, dostupne su vam besplatne jezičke usluge. Pozovite 1-833-574-6031 (TTY: 711).

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-833-574-6031 (TTY: 711)。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-574-6031 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-574-6031 (TTY: 711).

Italian: ATTENZIONE: Se parli italiano, hai a disposizione servizi gratuiti di assistenza linguistica. Chiama 1-833-574-6031 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-833-574-6031 (TTY: 711) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-574-6031 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नमिति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-833-574-6031 (टटिवाइ: 711) ।

Portuguese: ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Ligue para 1-833-574-6031 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-574-6031 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-574-6031 (TTY: 711).

Swahili: TAZAMA: Ikiwa unazungumza Kiswahili, huduma za usaidizi za lugha bila malipo zinapatikana kwa ajili yako. Piga simu kwa 1-833-574-6031 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-574-6031 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-574-6031 (TTY: 711).