SUMMIT HEALTH

Medicare Advantage Plans
Plan Selection Form

Date
Member Name
Member Number

Permanent residence street address (P.O. Box is not allowed)			
City	County	State	ZIP code
Mailing address (only if different from your permanent residence address)			
Street address			
City	County	State	ZIP code

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below:

Plan Details
(All cost-sharing amounts listed are for services provided in-network)

☐ Summit Health Core (HMO-POS) H2765-001

This plan is available to members living in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties in Oregon only.

Monthly Premium: $22
Out of Pocket Max: $4,200
Primary Care Visit Copay: $10
Specialist Visit Copay: $35

Inpatient Hospital Copay: $350/day for days 1-5, $0 days 6 and beyond
Emergency Room Visit Copay: $90
Durable Medical Equipment: 20%

☐ Summit Health Value + Rx (HMO) H2765-002

This plan is available to members living in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties in Oregon only.

Monthly Premium: $69
Out of Pocket Max: $6,850
Primary Care Visit Copay: $15
Specialist Visit Copay: $40

Inpatient Hospital Copay: $370/day for days 1-5, $0 days 6 and beyond
Emergency Room Visit Copay: $90
Durable Medical Equipment: 20%

☐ Summit Health Standard + Rx (HMO-POS) H2765-003

This plan is available to members living in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties in Oregon only.

Monthly Premium: $99
Out of Pocket Max: $6,250
Primary Care Visit Copay: $10
Specialist Visit Copay: $35

Inpatient Hospital Copay: $370/day for days 1-5, $0 days 6 and beyond
Emergency Room Visit Copay: $90
Durable Medical Equipment: 20%

☐ Summit Health Premier + Rx (HMO-POS) H2765-004

This plan is available to members living in Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties in Oregon only.

Monthly Premium: $146
Out of Pocket Max: $5,500
Primary Care Visit Copay: $10
Specialist Visit Copay: $35

Inpatient Hospital Copay: $350/day for days 1-5, $0 days 6 and beyond
Emergency Room Visit Copay: $90
Durable Medical Equipment: 20%

Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, eBill or "Electronic Funds Transfer" (EFT) 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.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ No change to current payment method

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month.

Please provide the following:
Account holder name: _____
Bank routing number: _____
Bank account number: _____
Account type: ☐ Checking ☐ Savings

☐ eBill, online premium payment

eBill is an online premium payment tool. When you receive your Summit Health member ID number, visit yoursummithealth.com and create your Member Dashboard. Once your Member Dashboard is created, click on the eBill tab to view and pay your monthly premium.

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

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. How premium is collected for months prior to the start of withholding depends on when your application is received and the effective date of enrollment. In some cases, Social Security/RRB deducts for those months once withholding begins. It's important to note that this means premium for multiple months may be deducted from a single benefit check. In other cases, you will receive paper bills and be responsible to pay us directly for months prior to the start of withholding. If Social Security or RRB does not approve your request for automatic deduction, we will send you paper bills for your monthly premiums on an ongoing basis.)

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ LARGE PRINT ☐ Spanish

Please contact Summit Health at **1-844-827-2355** (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Customer Service is available from 7 a.m. to 8 p.m., Pacific Time, seven days a week from Oct 1 through March 31 (after March 31, your call will be handled by our automated phone system Saturdays, Sundays and holidays).

Please check the appropriate box below:

Optional supplemental benefit:

☐ I currently have Extra Care and would like to keep it.
☐ I want to add Extra Care (a premium of $5 will be added to your medical premium).
☐ I no longer want Extra Care. Please disenroll me.

Please read and sign below

Signature: _____

Today's date: _____ / _____ / _____

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

Name: _____

Address: _____

Phone number: (_____) _____ Relationship to enrollee: _____

Please mail this form to:
Summit Health Plan, Inc.
Attn: Medicare Membership Accounting
P.O. Box 820070
Portland, OR 97282

Fax: 833-949-1891

Office use only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____ / _____ / _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

If you are an agent contracted with Summit Health Plan, Inc. you must provide the following,

Agency: _____

Date enrollment form received by agent: _____ / _____ / _____