



Dear Summit Health Medicare Advantage member,

To make a change in the Medicare Advantage plan you have with Summit Health Plan, Inc., fill out the enclosed plan selection form to make your choice. Check off the plan you want and sign the form. Then mail the completed form back to us.

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.

If you select another plan and we receive your completed selection form before the end of the month, your new benefit plan will begin the first of the following month. If you are changing plans October 15 – December 7 and we receive this plan change form before December 7, your plan will be effective January 1st of the following year. Your monthly plan premium is listed below the plan you selected on the plan change form and you may continue to see any Summit Health plan primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, review the Plan Selection form's benefit overviews or consult our 2023 Summary of Benefits for the plans available in your county.

If you have any questions, please call Customer Service at 844-827-2355 from 7 a.m. to 8 p.m., Pacific Time, seven days a week from October 1 through March 31, with the exception of Thanksgiving Day and Christmas Day. (After March 31, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays.). TTY users should call 711.



Medicare Advantage Plan Selection Form

Date
Member Name
Member Number

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

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: \$19

Out of Pocket Max: \$4,990

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: \$95

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: \$59

Out of Pocket Max: \$6,990

Primary Care Visit Copay: \$0

Specialist Visit Copay: \$40

Inpatient Hospital Copay: \$374/day for days 1-5,
\$0 days 6 and beyond

Emergency Room Visit Copay: \$95

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: \$89

Out of Pocket Max: \$5,880

Primary Care Visit Copay: \$0

Specialist Visit Copay: \$35

Inpatient Hospital Copay: \$350/day for days 1-5,
\$0 days 6 and beyond

Emergency Room Visit Copay: \$95

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: \$139

Out of Pocket Max: \$4,850

Primary Care Visit Copay: \$0

Specialist Visit Copay: \$35

Inpatient Hospital Copay: \$325/day for days 1-5,
\$0 days 6 and beyond

Emergency Room Visit Copay: \$95

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 monthly prescription drug premiums, 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 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 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 account number: _____

Bank routing 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 account 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.)

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. (Optional)

No, not of Hispanic, Latino/a or Spanish origin Yes, Puerto Rican
 Yes, Another Hispanic, Latino/a or Spanish origin Yes, Mexican, Mexican American, Chicano/a
 Yes, Cuban I choose not to answer

What’s your race? Select all that apply. (Optional)

American Indian or Alaska Native Chinese Japanese Other Asian
 Vietnamese Asian Indian Filipino Korean Other Pacific Islander
 White Black or African American Guamanian or Chamorro Native Hawaiian
 Samoan I choose not to answer

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 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, with the exception of Thanksgiving Day and Christmas Day. (After March 31, your call will be handled by our automated phone system Saturdays, Sundays and holidays.)

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
601 SW 2nd Ave
Portland, OR 97204-9748
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: ____ / ____ / _____