



2017
Medicare
Enrollment
Packet

(San Luis Valley)



Colorado Choice Health Plans
d/b/a San Luis Valley HMO

700 Main Street, Suite 100
Alamosa, CO 81101

Dessa Pottberg
Medicare Coordinator

719-589-3696
Fax: 719-589-4901
Toll Free: 800-475-8466
dpottberg@slvhmo.com



READY TO ENROLL?

Completing and returning the enclosed Application is your first step in becoming a Colorado Choice Medicare Plans (Cost) Member. **Please read the Summary of Benefits to determine which plan is right for you.** If you and your spouse are both applying, please fill out one Application for yourself and a separate one for your spouse.

Completing the Application Materials

- **Colorado Choice Medicare Plans (Cost) Application:** read & complete all required information

- ✓ Please complete pages 1 & 2 in its entirety – *be sure to provide your Medicare Card information on page 1*
- ✓ Carefully read the disclaimers on page 3
- ✓ Sign and date page 3

We recommend that you make a copy of this Application for your records.

- **Premium Payment Option (Form B):** choose one of the three payment options you wish to utilize for the payment of your monthly premium

- ✓ Please be sure to initial your payment option, sign & date the form (if you choose to have your premiums taken from one of your bank accounts *please complete, sign & date the section titled “AUTHORIZATION FOR AUTOMATIC TRANSFER OF FUNDS” and return with a copy of a voided check*).

- **First Month Premium:** Colorado Choice Medicare Plans (Cost) is a prepaid program; payment for your first month premium is required to be submitted with your Application.

- ✓ Please include a check or money order in the amount of your first month's premium

Mailing the Application Materials

Please mail the following materials to Colorado Choice Health Plans:

- ✓ Completed **Application**
- ✓ Completed **Premium Payment Option form** (including voided check, if applicable)
- ✓ Check or money order for your **first month's premium**

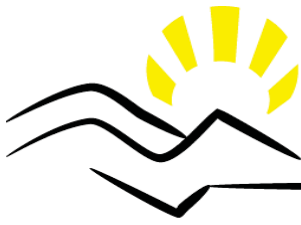
Mail to: Colorado Choice Health Plans
Attn: Enrollment Specialist
700 Main St, Suite 100
Alamosa, CO 81101

Contact our Enrollment Specialist if you would like further assistance in completing these forms.

This information is available for free in other languages. Please contact our customer service number at 1-800-475-8466 / TTY 1-800-659-2656, 8:00 a.m. to 8:00 p.m., 7 days a week.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de servicio al cliente al 1-800-475-8466, TTY 1-800-659-2656 de 8:00 am a 8:00 pm, los 7 días de la semana.

Colorado Choice Health Plans is a Cost plan with a Medicare contract. Enrollment in Colorado Choice's Medicare cost plan depends on contract renewal.



Colorado Choice Health Plans

700 Main Street, Suite 100
 Alamosa, CO 81101
 719-589-3696
 Fax: 719-589-4901
 www.cochoice.com

**To Enroll in COLORADO CHOICE SV PLANS (COST),
 Please Provide the Following Information:**

Please check which plan you want to enroll in:

- | | |
|--|--------------------------|
| <input type="checkbox"/> Colorado Choice Silver SV Plan (Cost) | Premium: \$20 per month* |
| <input type="checkbox"/> Colorado Choice Gold SV Plan (Cost) | Premium: \$45 per month* |
| <input type="checkbox"/> Colorado Choice Platinum SV Plan (Cost) | Premium: \$70 per month* |

*You must continue to pay your Part B premiums

Please indicate your requested enrollment effective date: _____

| | | | | | |
|------------|-------------|----------------|------------------------------|-------------------------------|------------------------------|
| LAST Name: | FIRST Name: | Middle Initial | Mr. <input type="checkbox"/> | Mrs. <input type="checkbox"/> | Ms. <input type="checkbox"/> |
|------------|-------------|----------------|------------------------------|-------------------------------|------------------------------|

| | | |
|--|--|----------------------|
| Birth Date: (__/__/____) (M M/D D/Y Y Y Y) | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Phone Number: () |
|--|--|----------------------|

Permanent Residence Street Address: _____

| | | |
|-------|--------|-----------|
| City: | State: | ZIP Code: |
|-------|--------|-----------|

Mailing Address (only if different from your Permanent Residence Address):

| | | | |
|-----------------|-------|--------|-----------|
| Street Address: | City: | State: | Zip Code: |
|-----------------|-------|--------|-----------|

Emergency contact: _____


Phone Number: _____ **Relationship to You** _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
-OR-
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part B to join a Medicare cost plan.

| | |
|---|----------------|
|  | |
| SAMPLE ONLY | |
| Name: _____ | Sex: _____ |
| Medicare Claim Number _____ | _____ |
| Is Entitled To | Effective Date |
| HOSPITAL (Part A) | _____ |
| MEDICAL (Part B) | _____ |

Your Plan Premium Payment Options

You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT), each month. You can also choose to pay your premium by automatic deduction from your Social Security Check each month.

If you don't select a payment option, you will receive a coupon book.

Please select a premium payment option:

- Receive a coupon book annually
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number: _____
Account type: Checking Saving
- Automatic deduction from your monthly SSA/RRB (Railroad Retirement Board) benefit check. (The SSA deduction may take two or more months to begin after Social Security/RRB approves the deduction. In most cases, if Social Security/RRB accepts your request for automatic deduction, the first deduction from your SSA/RRB benefit check will not include all premiums due from your enrollment effective date up to the point withholding begins. We will send you a coupon book for those months before deduction from your Social Security/RRB check starts. If Social Security/the RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? Yes No
Do you have health coverage through you or your spouse's current or former employer?
 Yes No

If "yes" please provide the following information:

Employer Name; _____ Employer Address: _____
Policy Holder Name: _____ Policy Number: _____

3. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):

Please check one of the boxes below if you would prefer us to send you information in a language other than English:

_____ Spanish
_____ Other: _____

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Colorado Choice Health Plans (Cost) is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to Colorado Choice Health Plans (Cost) or by calling 1-800-Medicare (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Colorado Choice Health Plans (Cost) services a specific area. If I move out of the area that Colorado Choice Health Plans (Cost) 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 Colorado Choice Health Plans (Cost), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Colorado Choice Health Plans (Cost) when I receive it to know which rules I must follow in order to receive coverage with the Medicare health plan.

I understand that beginning on the date Colorado Choice Plans (Cost) coverage starts, in order for Colorado Choice Health Plans (Cost) to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by Colorado Choice Health Plans (Cost). If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Colorado Choice Health Plans (Cost) and other services contained in my Colorado Choice Plans (Cost) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan 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 Colorado Choice Health Plans (Cost) or by Medicare.

| | |
|------------------------|----------------------|
| Your Signature: | Today's Date: |
|------------------------|----------------------|

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee: _____

Office Use Only:

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

Plan ID#: _____

[Enrollment Period when applicable] IEP: _____ AEP: _____ SEP (type): _____

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You must continue to pay your Medicare Part B premium.

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**COLORADO CHOICE HEALTH PLANS
PREMIUM PAYMENT OPTIONS**

700 Main Street, Suite 100, Alamosa, CO 81101

There are 3 ways you can pay your plan premium. Please initial the line for the premium payment option you wish to utilize

_____ **Option 1: You can pay by check, cash or money order.**
You may decide to pay your monthly plan premium directly to our Plan. You will receive a coupon book that contains monthly coupons that should accompany your payment in the form of check, money order, or cash. Colorado Choice Medicare Plans (Cost) are prepaid health plans, so your monthly premium is due no later than the 15th of the preceding month (For example, January premium is due prior to December 15th).

_____ **Option 2: You may use automatic withdrawal**
You can have your monthly plan premium automatically withdrawn from your bank account. . With this option, no invoice is mailed and you do not have to worry about mailing your payment on time. Simply complete the Account Deduction Authorization form and attach a voided check. Colorado Choice will automatically withdraw the monthly plan premium on the 15th of each month.

_____ **Option 3: You can have the plan premium taken out of our monthly Social Security check**
You can have your plan premium taken out of your monthly Social Security check. Our Customer Service will contact you to set-up paying your monthly plan premium this way.

AUTHORIZATION FOR AUTOMATIC TRANSFER OF FUNDS

By signing below, I authorize Colorado Choice Health Plans to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until Colorado Choice Health Plans has received written notification from the individual member of their termination in such time and in such manner as to afford Colorado Choice Health Plans and the Financial Institution a reasonable opportunity to act on it.

Member Name _____ Bank Name _____

Date of Monthly Automatic Transfer: between the 10th and 15th of each month

Routing # _____ Checking # _____ or Savings # _____

Authorized Signature _____ Date _____

Changing the way you pay your premium

Please contact Customer Service, if you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

For any questions, please contact our Customer Service Department.

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Colorado Choice Health Plans - H0657

2017 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2017, Colorado Choice Health Plans received the following Overall Star Rating from Medicare.


2.5 Stars

We received the following Summary Star Rating for Colorado Choice Health Plans's health/drug plan services:

Health Plan Services:  2.5 Stars
Drug Plan Services: Not Offered

The number of stars shows how well our plan performs.

| | |
|---|-------------------------|
|  | 5 stars - excellent |
|  | 4 stars - above average |
|  | 3 stars - average |
|  | 2 stars - below average |
|  | 1 star - poor |

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time at 800-475-8466 (toll-free) or 800-659-2656 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.

Current members please call 800-475-8466 (toll-free) or 800-659-2656 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.



Colorado Choice Health Plans - H0657

Calificaciones por estrellas Medicare 2017*

El Programa Medicare evalúa anualmente todos los planes de salud y medicamentos según la calidad y el rendimiento del plan. La calificación por estrellas de Medicare le ayuda a saber cómo se desempeña nuestro plan de salud. Usted puede utilizar estas calificaciones por estrellas para comparar el rendimiento de nuestro plan con los demás planes. Los dos tipos principales de calificaciones por estrellas son los siguientes:

1. Una calificación general por estrellas que combina los puntajes de nuestro plan.
2. Una calificación resumida por estrellas que se concentra en nuestros servicios médicos ó de medicamentos recetados.


Algunas de las áreas que el Programa Medicare analiza para estas calificaciones incluyen:

- Cómo nuestros miembros evalúan los servicios del plan de salud y de atención médica;
- Qué tan bien nuestros médicos detectan enfermedades y mantiene a nuestros miembros saludables;
- Qué tan bueno es nuestro plan en ayudar a los miembros a utilizar medicamentos recetados recomendados y seguros.

Para el año 2017, Colorado Choice Health Plans recibió la siguiente calificación general por estrellas de Medicare.






2.5 estrellas

Recibimos la siguiente calificación resumida por estrellas para los servicios de salud ó de medicamentos de Colorado Choice Health Plans

Servicios de Planes de Salud: 
2.5 estrellas

Servicios de Planes de Medicamentos: El beneficio no es ofrecido por el plan

El número de estrellas muestra que tan bien se desempeña nuestro plan.

| | |
|---|---------------------------------------|
|  | 5 estrellas - excelente |
|  | 4 estrellas - por encima del promedio |
|  | 3 estrellas - promedio |
|  | 2 estrellas - por debajo del promedio |
|  | 1 estrella - malo |

Conozca más sobre nuestro plan y cómo somos distintos a otros planes de salud, visitando el sitio web www.medicare.gov.

Usted nos puede contactar de 7 días a la semana de 8:00 a.m. a 8:00 p.m. hora de la Montaña al 800-475-8466 (libre de cargo) ó al 800-659-2656 (teléfono de texto) del 1 de octubre al 14 de febrero. Nuestro horario de atención para el resto del año es de 15 febrero al 30 septiembre lunes a viernes de 8:00 a.m. a 8:00 p.m. hora de la Montaña.

Miembros actuales por favor llamar al 800-475-8466 (libre de cargo) o al 800-659-2656 (teléfono de texto).

*Las calificaciones por estrellas están basadas en 5 estrellas. Las calificaciones por estrellas son evaluadas cada año y pueden cambiar de un año al otro.





Multi-Language Insert

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 [1-800-475-8466]. 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 llame al [1-800-475-8466]. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-475-8466。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康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 1-800-475-8466。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa [1-800-475-8466]. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au [1-800-475-8466]. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi [1-800-475-8466] sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter [1-800-475-8466]. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 [1-800-475-8466]번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону [1-800-475-8466]. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على [1-800-475-8466]. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें [1-800-475-8466] पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है 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 [1-800-475-8466]. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número [1-800-475-8466]. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan [1-800-475-8466]. Yon moun ki pale 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 znającego język polski, należy zadzwonić pod numer [1-800-475-8466]. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、[1-800-475 8466]にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。