BlueCross BlueShield Kansas

2026 Summary of Benefits

Blue MedicareRx Plus (PDP)
Blue MedicareRx Value (PDP)
Blue MedicareRx Essentials (PDP)

Prescription drug coverage available in all Kansas counties.

Effective from January 1, 2026 through December 31, 2026

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Introduction

This document is a summary of drug and health services covered by Blue MedicareRx (PDP).

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

Blue MedicareRx, offered by Blue Cross and Blue Shield of Kansas, is a PDP with a Medicare contract. Enrollment in this plan depends on contract renewal.

This information is not a complete description of benefits. Call **866-696-5072 (TTY: 711)** for more information.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you.
Call **866-696-5072 (TTY: 711)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Blue MedicareRx (PDP) covers and what you pay. If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at https://www.medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Who can join?

To be eligible for a Part D plan, you must be enrolled in Part A or Part B (Original Medicare).

You can choose to receive Part D coverage in addition to:

- Part A and/or Part B
- Part A and Part B with a Medicare Supplement insurance plan
- Medicare Advantage Plan (Part C) generally includes Part D

Our service area is available in all Kansas counties.

Hours of Operations

Our customer service is available 24 hours a day, 7 days a week.

Phone Numbers and Website

If you have any questions, call toll-free at **866-696-5072 (TTY:711)** or visit our website at bcbsks.com/medicare/pdp-welcome.

Which doctors, hospitals, and pharmacies can I use?

Blue Cross and Blue Shield of Kansas has a network of doctors, hospitals, pharmacies, and other providers. As a result, you may pay less for your covered benefits. However, you may also use providers that are not in our network.

Generally, you must use pharmacies in our network to fulfill your prescriptions for covered Part D Drugs.

Please call 866-640-2759 (TTY:711) or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

What drugs are covered?

You can see the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our website, bcbsks.com/medicare/pdp-welcome

Or, call us and we will send you a copy of the Formulary.

How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, day supply, and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the Plan for more information or access the Evidence of Coverage.

Blue MedicareRx Value (PDP)	Blue MedicareRx Plus (PDP)	Blue MedicareRx Essentials (PDP)
How much is my premium (monthly payment)?		
$0.70 per month	**$67.40** per month	**$0**
You must continue to pay your Medicare Part B premium.		
Stage 1: How much is my deductible?		
$615 deductible per year for Part D prescription drugs. Drugs listed on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty Tier are included in the Part D deductible. The Part D deductible does not apply to Insulin drugs.	This plan does not have a Part D deductible.	**$615** deductible per year for Part D prescription drugs. Drugs listed on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty Tier are included in the Part D deductible. The Part D deductible does not apply to Insulin drugs.
Stage 2: Initial Coverage		
After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **$2,100**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **$2,100**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	After you pay your yearly deductible (if your plan has one), you pay the amount listed in the table on the following pages, until your total yearly drug costs reach **$2,100**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Stage 2: Initial Coverage

You may get your covered drugs at retail pharmacies and mail-order pharmacies in our plan. Generally, you may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan. If you live in a long-term care facility, you pay the same as at a retail pharmacy.

Cost Sharing	Blue MedicareRx Value (PDP)	Blue MedicareRx Plus (PDP)	Blue MedicareRx Essentials (PDP)
Tier 1: Preferred Generic			
Preferred retail one-month supply	**$0 copay**	**$0 copay**	**$0 copay**
Standard retail one-month supply	**$7 copay***	**$5 copay**	**$5 copay***
Preferred mail order three-month supply	**$0 copay**	**$0 copay**	**$0 copay**
Tier 2: Generic			
Preferred retail one-month supply	**$2 copay***	**$0 copay**	**$0 copay***
Standard retail one-month supply	**$9 copay***	**$7 copay***	**$7 copay***
Preferred mail order three-month supply	**$6 copay***	**$0 copay**	**$0 copay**

* Your deductible will not apply for these drugs.

Stage 2: Initial Coverage			
Cost Sharing	**Blue MedicareRx Value (PDP)**	**Blue MedicareRx Plus (PDP)**	**Blue MedicareRx Essentials (PDP)**
Tier 3: Preferred Brand and Covered Insulin Drugs			
Preferred retail one-month supply	**18% coinsurance**	**20% coinsurance**	**20% coinsurance**
Preferred retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Standard retail one-month supply	**25% coinsurance**	**25% coinsurance**	**25% coinsurance**
Standard retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Preferred mail order three-month supply	**18% coinsurance**	**20% coinsurance**	**20% coinsurance**
Tier 4: Non-Preferred Drug and Covered Insulin Drugs			
Preferred retail one-month supply	**40% coinsurance**	**40% coinsurance**	**30% coinsurance**
Preferred retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Standard retail one-month supply	**50% coinsurance**	**50% coinsurance**	**50% coinsurance**
Standard retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Preferred mail order three-month supply	**40% coinsurance**	**40% coinsurance**	**30% coinsurance**

Stage 2: Initial Coverage			
Cost Sharing	**Blue MedicareRx Value (PDP)**	**Blue MedicareRx Plus (PDP)**	**Blue MedicareRx Essentials (PDP)**
Tier 5: Specialty Tier			
Preferred retail one-month supply	**25% coinsurance**	**33% coinsurance**	**25% coinsurance**
Standard retail one-month supply	**25% coinsurance**	**33% coinsurance**	**25% coinsurance**
Preferred mail order one-month supply	**25% coinsurance**	**33% coinsurance**	**25% coinsurance**

Blue Cross and Blue Shield of Kansas (BCBSKS) is a PDP plan with a Medicare contract. Enrollment in BCBSKS depends on contract renewal. BCBSKS is the legal entity that has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Part D plans noted. BCBSKS serves all counties in Kansas. BCBSKS is an independent licensee of the Blue Cross Blue Shield Association.

Form Approved
OMB# 0938-1421

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 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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 panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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 quí vị cần thông dịch viên xin gọi 1-866-421-5077 (TTY: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-421-5077 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-421-5077 (TTY: 711).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 1-866-421-5077 (TTY: 711). 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 فوري، ليس عليك سوى الاتصال بنا على 1-866-421- 5077 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना केबारे में आपकेकिसी भी परश्न केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया पराप्त करने केलिए, बस हमें 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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 1-866-421-5077 (TTY: 711). 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ございます。通訳をご用命になるには、1-866-421-5077 (TTY: 711).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。

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Blue Cross and Blue Shield of Kansas - S5726

For 2026, Blue Cross and Blue Shield of Kansas - S5726 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	Service not offered
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Blue Cross and Blue Shield of Kansas 7 days a week from 8:00 a.m. to 8:00 p.m. Central time at 866-696-5072 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. Current members please call 866-421-5077 (toll-free) or 711 (TTY).

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Scope of Sales Appointment Confirmation Form

BlueCross BlueShield Kansas

The Centers for Medicare & Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or his/her authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Section 1 – Please initial below beside the type of product(s) you want the agent to discuss.

_____ Stand-alone Medicare Prescription Drug Plans (Part D)

_____ Medicare Advantage Plans (Part C)

Section 2 – Beneficiary or Authorized Representative Authorization

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the product is either employed or contracted by a Medicare plan. The person does not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Your signature required

_____ _____ / _____ / _____
Applicant (Signature of authorized representative if other than applicant) Date Signed

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

_____ _____
Print Name Relationship to Beneficiary

Section 3 – (Required) To be completed by Agent

_____ _____
Beneficiary Name Agent Name

_____ (_____) _____ - _____
Beneficiary Address (optional) Agent Phone Number

_____ _____
City Initial Method/Location of Contact

_____ _____ _____ _____ ☐ Indicate here if beneficiary was a walk-in.
State ZIP Code +4 County

(_____) _____ - _____ _____
Beneficiary Phone (optional) Plan(s) the agent represented during this meeting

_____ _____ / _____ / _____
Medicare ID Number Date Appointment Completed

Your signature required

_____ _____ / _____ / _____
Agent Date Signed

Please continue on the next page.

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost plans, some Medicare Private Fee-for-Serivce plans, and Medicare Medical Savings Account plans.

Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) Plan: A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost.

Medicare Special Needs Plan (SNP): A special type of Medicare Advantage plan available the provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions. There are plans available to anyone who has both Medical Assistance from the State and Medicare, plans for people with diabetes, and plans for anyone with Medicare living in an assisted living facility (ALF) or living at home but has complex health issues which require comprehensive care.

Plan Use Only

Agent: Ensure correct Scope of Appointment form is selected for beneficiary's plan enrollment choice.

Scope of Appointment documentation is subject to CMS record retention requirements.

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 at 866-696-5072 (TTY: 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through 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 https://shop.partdkansas.com/medicare or call 866-696-5072 to view a copy of the EOC.

- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription 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

- [ ] Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care 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.

- [ ] 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, 2027.

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OMB No. 0938-1378
Expires: 12/31/2026

Individual Enrollment Request Form to Enroll in a Medicare Prescription Drug Plan (Part D)

BlueCross BlueShield Kansas

Who can use this form?
People with Medicare who want to join a Medicare Prescription Drug 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 Prescription Drug Plan, you must also have either, or 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 3 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 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 open enrollment (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:
Blue Cross and Blue Shield of Kansas
PO Box 517
Topeka, Kansas 66601-9872

Or fax to: 1-866-445-0417

You can also enroll online at:
www.bcbsks.com/partd

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

How do I get help with this form?
Call Blue Cross and Blue Shield of Kansas at **1-877-471-4121**. TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
TTY users can call 1-877-486-2048.
Customer Service is available 24 hours a day, 7 days a week.

En español: Llame a Blue Cross and Blue Shield of Kansas al 1-877-471-4121/711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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 0939-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Medicare Prescription Drug Plan Individual Enrollment Form – 2026

BlueCross BlueShield Kansas

Section 1 – Applicant Information (All fields in this section are required unless noted otherwise.)

Please select the plan you want to enroll in.

☐ 013 Blue MedicareRx Value (PDP) – $0.70 per month

☐ 014 Blue MedicareRx Plus (PDP) – $67.40 per month

☐ 020 Blue MedicareRx Essentials (PDP) – $0.00 per month

First Name _____ MI (Optional) _____

Last Name _____

Permanent Residence Street Address (Do not enter a P.O. Box)* _____

City _____

State _____ ZIP Code _____ +4 _____ County (Optional) _____

Mailing Address (if different from residential address; P.O. Box allowed) _____

City _____

State _____ ZIP Code _____ +4 _____

Sex ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

(_____) _____-_____
Phone Number

(_____) _____-_____
Alternate Phone Number

* For individuals experiencing homelessness, a P.O. Box may be considered your permanent resident address.

E-mail Address (Optional) _____

Thank you for providing your email address. Your email is used to send plan information and member communications. Please select which materials you would like to have emailed (you may select more than one):

☐ Plan documents

☐ Member communications

You will receive hard copies of specific plan documents on an annual basis and by request.

You can change your communications preferences at any time by visiting **www.myprime.com** or by contacting customer service.

Section 1A – Your Medicare Information

Enter the **11-digit alpha-numeric number** located on your Medicare card (for example: 1EG4-TE5-MK72).

Medicare Number _____

_____ /_____ /_____
Part A Effective Date

_____ /_____ /_____
Part B Effective Date

Section 1B – Other Prescription Drug Coverage

Will you have other prescription drug coverage (i.e., VA, TRICARE) in addition to Blue Cross and Blue Shield of Kansas? ☐ Yes ☐ No

Name of Other Coverage _____

Group Number of Other Coverage _____

Member Number of Other Coverage _____

_____ /_____ /_____
Start Date of Coverage

_____ /_____ /_____
End Date of Coverage

Please continue on the next page.

Section 2 – Additional Information

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

List your primary care physician (PCP), clinic or health center: _____

Text Message Consent:
You are not required to agree to receive calls or text messages to apply, enroll, or purchase a health plan.

☐ Yes, I consent to receive calls or text messages from Blue Cross and Blue Shield of Kansas and its subsidiaries to the phone number(s) previously provided about Medicare Supplement plans, including important updates, reminders, benefit information, and promotional or marketing materials. I understand and agree that calls or text messages may use an automatic telephone dialing system or an artificial or prerecorded voice. Message and data rates may apply. Frequency may vary. I understand I can opt out at any time.

☐ No, I do not wish to receive text messages at this time.

Section 3 – Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail or by electronic funds transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

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. Do not pay Blue Cross and Blue Shield of Kansas the Part D-IRMAA.

Please select a premium payment option. If you don't select a payment option, you will get a bill each month.

☐ **Monthly Bill:** Send me a bill each month

☐ **Automatic Bank Account Deduction:** Electronic funds transfer (EFT) from my bank account each month. (Depending on when you apply, more than one month's amount might be deducted for your first payment.

Select the account type to deduct from:

☐ Checking (you may enclose a **voided** check or provide the account information at right)

☐ Savings (you **must** enclose a letter from your financial institution with the account and routing information)

_____
Account Holder Name

_____
Bank Name

_____
Bank Routing Number

_____
Bank Account Number

I authorize the bank noted above to deduct my monthly premiums.

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

The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. 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 withholding begins. If Social Security or RRB delays or does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 4 – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Prescription Drug Plan (PDP) only during the Annual Enrollment Period (AEP) between October 15 and December 7 of each year. Additionally, there are exceptions – i.e., Initial Enrollment Period (IEP) and Special Enrollment Periods (SEPs) – that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period.

Please read the following statements carefully and check all of the boxes where there is a statement that 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.

NOTE: At least one option below needs to be selected to enroll.

- ☐ I am enrolling during the Annual Open Enrollment Period from October 15 through December 7. (AEP)
- ☐ I am new to Medicare. (IEP)
- ☐ I am turning 65 and not new to Medicare. (IEP2)
- ☐ I recently moved outside the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____ /_____ /_____. (SEP)
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get extra help paying for my Medicare prescription drug coverage, but I haven't had a change. (SEP)
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____ /_____ /_____. (SEP)
- ☐ I was affected by an emergency or major disaster, as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local governmental entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster. (SEP)
- ☐ I recently had a change in my Medicaid/Extra Help paying for my Medicare prescription drug coverage (newly got Medicaid/Extra Help, had a change in the level of Medicaid/Extra Help, or lost Medicaid/Extra Help) on (insert date) _____ /_____ /_____. (SEP)
- ☐ I am moving into, live in or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____ /_____ /_____. (SEP)
- ☐ I recently left a Program of All-inclusive Care for the Elderly (PACE®) program on (insert date) _____ /_____ /_____. (SEP)
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____ /_____ /_____. (SEP)
- ☐ I am leaving employer or union coverage. Employer/union coverage started on (insert date) _____ /_____ /_____ and coverage ends on (insert date) _____ /_____ /_____. (SEP)
- ☐ I belong to a pharmacy assistance program provided by my state. (SEP)
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____ /_____ /_____. (SEP)

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 4 – Attestation of Eligibility for an Enrollment Period (continued)

☐ My plan is ending its contract with Medicare or Medicare is ending its contact with my plan. (SEP)

☐ I was recently released from incarceration. I was released on (insert date) ____ /____ /_____. (SEP)

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date) ____ /____ /_____. (SEP)

☐ Other* _____

*If none of these statements apply to you or you're not sure, please contact Blue Cross and Blue Shield of Kansas at **1-877-471-4121** (TTY users should call 711) to see if you are eligible to enroll. Licensed sales agents are available 8:00 a.m. to 8:00 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31; and Monday through Friday (except holidays) from April 1 through September 30.

Section 5 – Information Preferences

Please send me materials in another format:

☐ Braille ☐ Large print ☐ Audio tape ☐ Data CD

Please contact Blue Cross and Blue Shield of Kansas at 1-877-471-4121 (TTY:711) if you need information in an accessible format or language other than what is listed above. You can reach customer service 24 hours a day, 7 days a week.

Applicant complete: _____ _____
Name Medicare Number

Please continue on the next page.

Section 6 – Authorization

Please read the following and sign below.

- I acknowledge I must keep Hospital (Part A) or Medical (Part B) to stay in Blue MedicareRx Value (PDP), Blue MedicareRx Plus (PDP) or Blue MedicareRx Essentials (PDP).
- By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Cross and Blue Shield of Kansas will share my information with Medicare, who may use it to track my enrollment, to make payments, 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 Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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, and 2) documentation of this authority is available upon request by Medicare.

Your signature required

_____ Applicant

_____ / _____ / _____ Date Signed

_____ Print Name

_____ / _____ / _____ Desired Plan Effective Date*

*Subject to Medicare electon period guidelines.

Section 7 – Authorized Representative Information

All fields in this section must be completed if the application has been signed by an Authorized Representative and not the Applicant.

_____ First Name

_____ MI

_____ Address

_____ Last Name

_____ City

(_____) _____-_____ Phone Number

_____ Relationship to Enrollee

_____ State

_____ ZIP Code

_____ +4

☐ I have submitted Authorized Representative documentation with this application.

Applicant complete: _____ Name

_____ Medicare Number

Please continue on the next page.

Section 8 – Agent/Broker

Applicant: Please do **not** complete the following sections.

Agent/Broker: Please fill in **all** fields including "Writing Agent" and "Agency" with your assigned Encrypted ID, Code or Tax ID based on your appointed brand, state and product.

☐ IEP ☐ AEP ☐ OEP ☐ SEP _____
Type

☐ Not eligible

I helped the applicant fill out this application. ☐ Yes ☐ No

Scope of Appointment (SOA)

Appointment type:

☐ Face-to-face

☐ Telephone

How was the SOA collected?

☐ Paper

☐ Electronic

☐ Recorded call _____
Voice Recording ID

_____
NPN Number

_____
First Name

_____
Last Name

_____
Writing Agent Encrypted TIN (10 digits)

_____
Agency Encrypted TIN (10 digits)

_____
Agency Name

(_____) _____-_____
Phone Number

_____
E-mail Address

_____
Representative Relationship to Applicant

1 – Agent
2 – Broker
3 – SHIP Counselors
4 – Authorized Rep
5 – Other third parties
6 – Self

Your signature required

_____
Signature of Agent/Broker

_____ / _____ / _____
Date Signed

Blue Cross and Blue Shield of Kansas offers PDP plans with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Kansas PDP plans depends on contract renewal. Blue Cross and Blue Shield of Kansas PDP plans are offered in all counties in Kansas. The above information is not a complete description of benefits. Call 800-471-2121 (TTY:711) for more information.

Translation services are available; please contact the plan or your agent.

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. Section 1851 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.

Applicant complete: _____ _____
Name Medicare Number

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BlueCross BlueShield Kansas

866-696-5072 (TTY: 711)

bcbsks.com/PDPwelcome

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Topeka, KS 66629-0001