BlueCross BlueShield Kansas

2027 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, 2027 through December 31, 2027

An independent licensee of the Blue Cross Blue Shield Association.

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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 Prescription Drug Plan (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 join one of our plans, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B and live in our service area.

Our service area includes all Kansas counties.

Medicare Part D is available regardless of income. Your income does not determine whether you can enroll, but it may affect whether you qualify for Extra Help or how much you have to pay for a standalone Part D plan.

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 pharmacies can I use?

Blue Cross and Blue Shield of Kansas has a network of 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)?		
$15.30 per month	**$167** per month	**$45.30** per month
You must continue to pay your Medicare Part B premium.		
Stage 1: How much is my deductible?		
$700 deductible per year for Part D prescription drugs. Deductible applies to all Drug Tiers. The Part D deductible does not apply to Insulin drugs.	**$350** 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.	**$700** 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 **$2,400**. 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 **$2,400**. 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 **$2,400**. 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	**$5 copay**	**$4 copay***	**$4 copay***
Preferred mail order three-month supply	**$0 copay**	**$0 copay***	**$0 copay***
Tier 2: Generic			
Preferred retail one-month supply	**$1 copay**	**$0 copay***	**$0 copay***
Standard retail one-month supply	**$7 copay**	**$5 copay***	**$5 copay***
Preferred mail order three-month supply	**$3 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	**20% 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	**20% coinsurance**	**20% coinsurance**	**20% coinsurance**
Tier 4: Non-Preferred Drug and Covered Insulin Drugs			
Preferred retail one-month supply	**35% coinsurance**	**26% coinsurance**	**30% coinsurance**
Preferred retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Standard retail one-month supply	**40% coinsurance**	**35% coinsurance**	**40% coinsurance**
Standard retail one-month Insulin supply	**$35 copay**	**$35 copay**	**$35 copay**
Preferred mail order three-month supply	**35% coinsurance**	**26% 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**	**29% coinsurance**	**25% coinsurance**
Standard retail one-month supply	**25% coinsurance**	**29% coinsurance**	**25% coinsurance**
Preferred mail order one-month supply	**25% coinsurance**	**29% coinsurance**	**25% coinsurance**

Blue Cross and Blue Shield of Kansas offers prescription drug plans (PDP) with a Medicare contract. Enrollment depends on contract renewal. Blue Cross and Blue Shield of Kansas prescription drug plans are available in all Kansas counties. Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross Blue Shield Association. Blue Cross and Blue Shield of Kansas is not endorsed by the U.S. Government or the federal Medicare program. Every year, Medicare evaluates plans based on a five-star rating system.

Nondiscrimination and Language Accessibility Statement and Notice:

Discrimination is Against the Law

Blue Cross Blue Shield of Kansas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Kansas does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, etc.).
- 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 reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Laurie Stratton.

If you believe that Blue Cross and Blue Shield of Kansas 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 with: Laurie Stratton, Director Customer Service, 1133 SW Topeka Blvd, Topeka, KS 66629 Attn: Special Services, 1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0785, email: special.services@bcbsks.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Laurie Stratton, Director Customer Service 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/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Blue Cross and Blue Shield of Kansas website: https://www.bcbsks.com.

Y0176_Nondiscrimination_Form1557_C

Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross Blue Shield Association.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (92.11)

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-432-3990 or speak to your provider.

Spanish: ATENCIÓN: Si habla espariol, tiene a su disposición servicios gratuitos de asistencia lingüstica. Tambien estan disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar informaci6n en formatos accesibles. Llame al 1-800-432-3990 o hable con su proveedor.

Traditional Chinese: 注意：如果您說[台語] , 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-800-432-3990 或與您的提供者討論。

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-432-3990 o makipag-usap sa iyong provider.

French: ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-432-3990 ou parlez à votre fournisseur.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-432-3990 hoặc trao đổi với người cung cấp dịch vụ của bạn.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-432-3990 an oder sprechen Sie mit Ihrem Provider.

Korean: 주의: [한국어] 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-432-3990 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Persian:

اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان در دسترس شما قرار دارد. کمک‌های فرعی مناسب و خدمات ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان ارائه می شوند. به 1-800-435-3990 تماس بگیرید یا با فراهم کننده خود صحبت کنید.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-432-3990 или обратитесь к своему поставщику услуг.

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-432-3990 أو تحدث إلى مقدم الخدمة.

Japanese: 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-432-3990 までお電話ください。または、ご利用の事業者にご相談ください。

Laotion: ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-432-3990 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Hmong: LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-432-3990 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Swahili: MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-432-3990 au zungumza na mtoa huduma wako.

Burmese:

မြန်မာ

သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရနိုင်ပါသည်။ အသုံးပြုနိုင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-432-3990 သို့ဖုန်းခေါ်ပါ သို့မဟုတ် သင်၏ ဆောင်ရွက်ပေးသူနှင့် စကားပြောပါ

IMPORTANT INFORMATION:

2027 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Blue Cross and Blue Shield of Kansas - S5726

For 2027, Blue Cross and Blue Shield of Kansas - S5726 received the following Star Ratings from Medicare:

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

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 Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern time at 866-696-5072 (toll-free) or 711 (TTY). Current members please call 866-421-5077 (toll-free) or 711 (TTY).

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.

_____ Medicare Advantage Plans (Part C)

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

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

_____ (_____) _____-_____

Address Phone Number

_____ _____

City Email

_____ _____ _____

State ZIP Code +4

Medicare Advantage Plans (Part C)

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 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-Service plans, and Medicare Medical Savings Account plans.

Section 3 – (Required) To be completed by Agent

Beneficiary Name

Beneficiary Address (optional)

City

State ZIP Code +4 County

(_____) _____-_____
Beneficiary Phone (optional)

Medicare ID Number

Agent Name

(_____) _____-_____ _____
Agent Phone Number NPN Number

Initial Method/Location of Contact

☐ Indicate here if beneficiary was a walk-in.

Plan(s) the agent represented during this meeting

_____ / _____ / _____
Date Appointment Completed

Representative Relationship to Applicant

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

If this Scope of Appointment (SOA) was obtained at the time of appointment, provide the reason the SOA was not completed prior to Appointment (please check all that apply):

☐ Unplanned attendee

☐ Walk-in

☐ New SOA required (consumer requested other Health Product information)

☐ Other (please explain)

Section 4 – Agent Authorization

Your signature required

Agent

_____ / _____ / _____
Date Signed

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. Blue Cross and Blue Shield of Kansas offers PPO plans with a Medicare contract. Enrollment depends on contract renewal. Blue Cross and Blue Shield of Kansas Medicare Advantage plans are available within a limited number of Kansas counties. Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross Blue Shield Association.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-6650 (TTY: 711).

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), available 24 hours a day, 7 days a week.

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 Prescription Drug plan, your current coverage will end once your new Prescription Drug plan starts. If you are currently enrolled in a Medicare Advantage Prescription Drug plan, your coverage will end once your new Prescription Drug Plan coverage starts.

- [ ] 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.

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OMB No. 0938-1378
Expires: 02/28/2029

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 Oct. 15 – Dec. 7 each year (for coverage starting Jan. 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 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 (Oct. 15 – Dec. 7), the plan must get your completed form by Dec. 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 – 2027

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) – $15.30 per month

☐ 014 Blue MedicareRx Plus (PDP) – $167 per month

☐ 020 Blue MedicareRx Essentials (PDP) – $45.30 per month

First Name _____ MI (Optional) _____

Last Name _____

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

City _____

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

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

City _____

State _____ ZIP Code _____ +4 (Optional) _____

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 (Optional)

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

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 ealectronic 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.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-dextra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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 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 Oct. 15 and Dec. 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 enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I am enrolling during the Annual Open Enrollment Period from Oct. 15 through Dec. 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 United States. 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 Oct. 1 through March 31; and Monday through Friday (except holidays) from April 1 through Sept. 30.

Section 5 – Information Preferences

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

_____ Print Name

_____ Signature

_____ Relationship To Enrollee

_____ National Producer Number (Agents/Brokers only)

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 Prescription Drug Plans (PDP) 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 800-471-4121 (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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866-696-5072 (TTY: 711)

bcbsks.com/PDPwelcome

1133 SW Topeka Blvd.
Topeka, KS 66629-0001