C AND O EMPLOYEES' HOSPITAL ASSOCIATION

511 MAIN STREET, 2nd FLOOR
CLIFTON FORGE, VIRGINIA 24422-1166
TELEPHONE (540) 862-5728/5729 (800) 679-9135 FAX (540) 862-3552/4958

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C and O Employees' Hospital Association
Medicare Supplement & Part D Enrollment Form

To Enroll in the C and O Employees' Hospital Association (COEHA), Please Provide the Following Information:

PLEASE TYPE OR PRINT. Please check the plan in which you want to enroll:

___Plan Seven which includes hospital, medical and Medicare Part D Prescription Drug coverage. $300.00 per month

___Plan Ten which is hospital and medical coverage only. $200.00 per month

LAST name:	FIRST name: Middle Initial:	
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M or F (circle) Social Security Number ____ ____ ____	Home Phone Number: ( ) ____
Permanent Residence Street Address (P.O. Box is not allowed):		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address): _____
Street Address: City: State: ZIP Code: _____

Emergency contact person: _____

Phone Number: (___) _____ **Relationship to You:** _____
E-mail Address:

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have both Medicare Part A and Part B to join our Supplemental Medicare plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ ___ ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Date you wish your Medicare Supplemental coverage to begin: ____/____/_____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed

Name of the railroad (or other company) from which you retired if other than CSX _____

If you are the spouse or family member of a COEHA member, please give member's name and Social Security Number: _____ _____-_____-_____

COEHA MEDICARE HEALTH CARE PREPAYMENT PLAN (HCPP):

As a member of our Medicare Supplemental Plan, you are automatically enrolled in the COEHA Medicare Health Care Prepayment Plan. As an HCPP, we are contracted with the federal government as an HCPP Carrier for the HCPP Medicare members and will process the Medicare Part B claims from COEHA network participating physicians. COEHA shall pay medically necessary Medicare Part B (medical) HCPP Health Care services in one combined payment to include primary and secondary payment. We will be paid a fee from the federal government for processing your physician's claims for Medicare benefits.

Advantages for you:

- Handling of your Part B Medicare services will be expedited since claims will be filed and processed at one location: COEHA
- You will never receive a bill from your physician for covered Medicare services
- You will never have to file a physician's claim with COEHA
- You will never have to call or write Medicare in regard to your physician's services

Advantages for your COEHA network physician:

- COEHA physicians will receive their monies much faster
- COEHA physicians will only have to file one claim to one location: COEHA
- COEHA physicians never have to send you a bill – they reduce their costs
- COEHA physicians will never have to call Medicare regarding your benefits – they reduce their costs

ADVANCE DIRECTIVE INFORMATION:

This will acknowledge that I received from COEHA, at the time of enrollment, information concerning an advance directive. This information explains my right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at my option, an advance directive concerning my care. I further understand that a form of advance directive is available to me from COEHA upon request if I do not have one.

Paying Your Plan Premium

You can pay your plan premium by mail each month, quarterly, semi-annually or annually. Your monthly premium can also be deducted thru "Electronic Funds Transfer (EFT)". This deduction is made on the 5th of each month or first business day thereafter.

If you owe any Late Enrollment Penalty, this penalty will need to be mailed to us separately from your plan premium. This Penalty is billed twice annually, or we can bill you monthly at your request.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to the C and O Employees' Hospital Association.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Late Enrollment Penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call 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.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay part of your plan premium. Effective January 1, 2018, we have contracted with Navitus MedicareRx to administer your Medicare Part D Prescription Drug Plan. Since this is an enhanced Part D Plan, you will be responsible for a portion of your prescription drug plan premium.

If you don't select a payment option, you will receive a bill each month.
Please select a premium payment option: (check only one)

A._____I have enclosed the first dues payment and wish to pay monthly, quarterly, semi-annually or annually. Payment is due on the 5th of the month. If payment has not been received by the 14th of the month, I will receive a bill.

B. _____I do hereby authorize The C and O Employees Hospital Association to have my dues premium withdrawn from my checking account. My current rate is $____. I understand that this premium may increase, and I may cancel at any time. I understand this premium will be deducted on the fifth of each month. Enclosed is a voided blank check from my checking account.

Account holder name:_____ Account Type: _____Checking _____ Savings
Bank routing number: _____ Bank account number _____

Please Answer the following Questions:

1. Some individuals may have other supplemental and/or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Are you or your spouse currently employed? ____ Yes ____No
Do you currently have prescription drug coverage? ____Yes ____ No
If yes, please answer the following questions: Is your current prescription drug plan a Medicare Part D Plan?
Yes_____ No_____
If your current prescription drug plan is not a Medicare Part D Plan, does it cover as much as a Medicare Part D Plan? Do you have a letter stating your coverage is creditable? Yes_____ No _____
Please provide us with a copy of the letter.
Will you have other Medicare supplemental coverage in addition to COEHA? ____Yes ____No
If yes, please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: ID # for this coverage: Group # for this coverage:

_____ _____ _____
Phone Number (____)_____

2. Are you a resident in a long-term care facility, such as a nursing home? ____ Yes ____No
If yes, please provide the following information:
Name of Institution: _____
Address of Institution (number and street):_____
Phone Number (_____)_____ Date of Admission: _____

3. Do you receive Medicaid benefits?____ Yes ____ No

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining COEHA, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining COEHA could affect your employer or union health benefits. You could lose your employer or union health coverage if you join COEHA. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below:

By completing this enrollment application, I agree to the following:
Navitus MedicareRx is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. It is my responsibility to inform COEHA of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a

time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in COEHA will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

I understand that I must use Navitus MedicareRx network pharmacies except in an emergency when I cannot reasonably use their network pharmacies. Once I am a member of COEHA, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Navitus MedicareRx when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a Late Enrollment Penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:
By joining this Medicare Supplemental and prescription drug plan, I acknowledge that COEHA will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Navitus MedicareRx will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 Medicare.

Signature: _____Today's Date_____.

If you are the authorized representative, you must sign above and provide the following information:
Name: _____Address:_____Phone No._____Relationship_____

Answering these questions is your choice.

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

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

What's your race? Select all that apply.

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

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

_____ Braille _____ Large print _____ Audio CD

Please contact the C and O Employees Hospital Association at 1-800-679-9135 or (540) 862-5728 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Thursday 8:30-5:00 and Friday 8:30- 4:00. TTY users can call 711.

All organizations that provide Medicare Managed Care Plans, and Health Care Prepayment Plans, like COEHA, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Discrimination is against the law. COEHA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. COEHA does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

COEHA:

- Provides 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, and other formats)
- Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Ms. Michelle Hoke, the Civil Rights Coordinator.

If you believe that COEHA 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:

Michelle Hoke
C and O Employees' Hospital Association
427 E. Ridgeway Street
Clifton Forge, Virginia 24422-1326
(800) 679-9135 (toll free), TTY/TDD users call 711 for all states
(540) 862-3552 (fax)
michellehoke@coeha.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ms. Michelle Hoke, Civil Rights Coordinator, is available to help you.

You can contact CMS directly if your grievance is not resolved by the Plan or if you believe that your grievance was not resolved correctly. You can file a grievance with CMS by doing one of the following:

1. Calling 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676;
2. Sending a fax to 1-844-530-3676;
3. Sending an email to AltFormatRequest@cms.hhs.gov ; or
4. Sending a letter to: Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries 7500 Security Boulevard, Room S1-13-25 Baltimore, MD 21244-1850 Attn: CMS Customer Accessibility Resource Staff.

CMS expects individuals to file the complaint within 180 calendar days of the alleged discrimination.

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. The complaints must be filed within 180 days of the date of the alleged discrimination.

Virginia Top 15 Languages:

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-679-9135.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-679-9135 번으로 전화해 주십시오.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-679-9135.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-679-9135.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-679-9135
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-679-9135.
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-679-9135 تماس بگیرید.
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-679-9135.
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-679-9135
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-679-9135.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-679-9135.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-679-9135 पर कॉल करें।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-679-9135.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-800-679-9135
Kru (Bassa)	Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-800-679-9135.
Ibo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-679-9135.
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-679-9135.