



MedicareBlueSM Rx (PDP)

A Medicare Prescription Drug Plan



2026 Enrollment Guide

A drug plan that works with your health plan

MedicareBlueSM Rx (PDP) is a Part D prescription drug plan with two coverage options, Standard and Premier, that provides coverage for the drugs you may take today or may need in the future. MedicareBlue Rx could be a good fit for you if:

- You have Medicare Part A, Part B or both
- You are enrolled or plan to enroll in a Medicare supplement insurance plan (Medigap)
- You currently take prescription drugs, or think you may in the future

Enrolling in a prescription drug plan can also help you avoid the Part D late enrollment penalty. If you don't enroll in a Part D plan when you first become eligible, you may have to pay a penalty if you decide to enroll later. This penalty is added to your monthly premium and you will pay it for as long as you remain enrolled in a Part D plan.

Convenient coverage with a nationwide pharmacy network

- **Coverage you can rely on:** MedicareBlue Rx provides coverage for generic, brand-name, and specialty prescription drugs
- **Nationwide pharmacy network:** Fill your prescription at pharmacies across the U.S. or have prescriptions delivered to you
- **Save with special rates:** Thousands of pharmacies in our network offer preferred cost sharing, meaning you could save with participating network pharmacies across the U.S., including independent pharmacies, national chains, and more

Financial assistance program: Extra Help

You may be able to get financial assistance with your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **Your State Medicaid office**
- **Social Security Administration**
1-800-772-1213 (TTY: **1-800-325-0778**)
8 a.m. to 7 p.m., Monday through Friday
Automated telephone services available 24 hours a day, 7 days a week
- **Medicare**
1-800-633-4227 (TTY: **1-877-486-2048**)
24 hours a day, 7 days a week

Medication therapy management program

If you meet certain requirements, MedicareBlue Rx provides a medication therapy management (MTM) program at no cost. The program helps you and your doctor make sure your medications are appropriate for your needs. You may be eligible for this program if you:

- Take eight or more Part D covered maintenance drugs
- Have three or more long-term health conditions, such as asthma and diabetes
- Reach \$1,276 in annual drug costs paid by you and MedicareBlue Rx

Learn more about the eligibility requirements at YourMedicareSolutions.com/MTM.

Enroll now



Online

Visit YourMedicareSolutions.com to complete enrollment securely online



Phone

Call **1-866-434-2037** (TTY: **711**) daily, 8 a.m. and 8 p.m., Central and Mountain times



Licensed agent

Discuss your options and complete the enrollment process in person or over the phone

Enrollment eligibility and timing




You can enroll in MedicareBlue Rx regardless of your income or health if you:

- Have Medicare Part A and/or Part B
- Live in the service area (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, or Wyoming)
- Are a U.S. citizen or lawfully present in the U.S.

Contact our Medicare Solutions specialists or your local licensed sales agent if you have questions about enrollment eligibility.

When to enroll

Knowing when you can enroll, disenroll, and make changes to your prescription drug plan is important so that you can avoid enrollment penalties and lapses in coverage. Review the summary of Medicare enrollment dates below to determine when you can enroll in MedicareBlue Rx.

|  Time period |  What you can do |  When you can do it |
|--|--|---|
| Initial enrollment period (IEP) | Enroll in a Part D prescription drug plan, Medicare Advantage (MA) plan or MA plan with prescription drug coverage | Three months prior to, the month of, or three months after you turn 65. Or, after month 24 of receiving disability benefits |
| Annual enrollment period (AEP) | Existing Medicare beneficiaries can enroll in or change to a Part D prescription drug plan, Medicare Advantage (MA) plan or MA plan with prescription drug coverage | Each year from October 15 to December 7 (coverage effective January 1 of the following year) |
| Medicare Advantage open enrollment period (MA OEP) | Disenroll from a Medicare Advantage (MA) plan and enroll in another MA plan, with or without Part D coverage, or Original Medicare and, if needed, a stand-alone Part D plan | Each year from January 1 to March 31 (change effective the first of the month after you submit the request) |
| Special enrollment period (SEP) | Enroll in a Part D prescription drug plan or Medicare Advantage plan | If you qualify for an SEP, you can enroll after your IEP or the AEP has ended |

MedicareBlueSM Rx (PDP) 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 Medicare Solutions Specialist at **1-866-434-2037** (TTY: **711**), 8 a.m. to 8 p.m., daily, Central and Mountain times.

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 **YourMedicareSolutions.com** to view a copy of the EOC or call **1-866-434-2037** (TTY: **711**), 8 a.m. to 8 p.m., daily, Central and Mountain times.
- ☐ Review the *pharmacy directory* to make sure the pharmacy you use for any prescription medicine 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

- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2027.
- ☐ **Effect on Current Coverage:** If you are currently enrolled in a Medicare Prescription Drug Plan, your coverage will end once your new Prescription Drug Plan coverage 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.

MedicareBlueSM Rx (PDP) is a prescription drug plan with a Medicare contract. Enrollment in MedicareBlue Rx depends on contract renewal.

Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa*; Blue Cross and Blue Shield of Minnesota*; Blue Cross and Blue Shield of Montana*, a division of Health Care Service Corporation, a Mutual Legal Reserve Company; Blue Cross and Blue Shield of Nebraska*; Blue Cross Blue Shield of North Dakota*; Wellmark Blue Cross and Blue Shield of South Dakota*; and Blue Cross Blue Shield of Wyoming*.

*Independent licensees of the Blue Cross and Blue Shield Association.



2026 SUMMARY of BENEFITS

MedicareBlueSM Rx (PDP) Standard

January 1, 2026 – December 31, 2026

INTRODUCTION

This guide is a summary of the prescription drug services offered by MedicareBlueSM Rx (PDP). This booklet includes an overview of our plan and pharmacy network, an easy-to-read chart of plan benefit information and contact information for customer service representatives who are available to answer your questions.

WHAT'S INCLUDED

| | |
|--|---|
| MedicareBlue Rx Standard plan overview | 1 |
| Frequently asked questions | 2 |
| Using the plan | 3 |

CONTACT MEDICAREBLUE RX



YourMedicareSolutions.com



| | |
|----------------------------------|----------------------------------|
| Members | Non-members |
| 1-888-832-0075 (TTY: 711) | 1-866-434-2037 (TTY: 711) |

Call toll-free from 8 a.m. to 8 p.m., daily, Central and Mountain times

MEDICAREBLUE RX STANDARD PLAN OVERVIEW

This chart shows how much you will pay each month for your premium, the plan's deductible and how much you will pay for your prescriptions.

| Premiums & benefits | MedicareBlue Rx Standard | |
|---|--------------------------|-----------------------|
| Monthly plan premium | \$101 | |
| Deductible | \$615 | |
| Initial coverage | Preferred cost sharing | Standard cost sharing |
| 30-day supply from a network pharmacy | | |
| Tier 1: Preferred generic | \$0 copay | \$5 copay |
| Tier 2: Generic | \$1 copay | \$7 copay |
| Tier 3: Preferred brand | 22% coinsurance | 25% coinsurance |
| Tier 4: Non-preferred drug | 42% coinsurance | 50% coinsurance |
| Tier 5: Specialty | 25% coinsurance | 25% coinsurance |
| 90-day supply from a network pharmacy or mail order | | |
| Tier 1: Preferred generic | \$0 copay | \$15 copay |
| Tier 2: Generic | \$3 copay | \$21 copay |
| Tier 3: Preferred brand | 22% coinsurance | 25% coinsurance |
| Tier 4: Non-preferred drug | 42% coinsurance | 50% coinsurance |
| Tier 5: Specialty | Not available | Not available |
| Catastrophic coverage | | |
| The catastrophic coverage stage begins after you reach \$2,100 in out-of-pocket prescription drug costs. If you reach the catastrophic coverage phase, you won't have to pay a copayment or coinsurance for covered drugs. Out-of-pocket costs include the amount paid for covered drugs for the calendar year. This does not include the amount the plan has paid or the plan premium. | | |

FREQUENTLY ASKED QUESTIONS

WHAT IS MEDICAREBLUE RX (PDP)?

MedicareBlue Rx is a prescription drug plan (PDP) that works with your Medicare benefits. Not all covered services are listed in this booklet. To see a complete list of covered services, call MedicareBlue Rx and ask for the *Evidence of Coverage*. The phone numbers are listed on the inside front cover. You can also visit **YourMedicareSolutions.com** to view the electronic version.

CAN I JOIN?

To join, you must be entitled to Medicare Part A and/or enrolled in Part B and live in our service area, which includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming.

ARE MY DRUGS COVERED?

Check the formulary, also called a drug list, at **YourMedicareSolutions.com**, or call MedicareBlue Rx and we will send you a copy.

HOW MUCH WILL I NEED TO PAY FOR PRESCRIPTION DRUGS?

The amount you pay depends on what tier the drug is on and what benefit stage you have reached. Your costs for each drug tier and benefit stage are shown in the benefit chart in this booklet.

WHICH PHARMACIES CAN I USE?

In general, use the pharmacies in the plan's network to fill your prescriptions. Some pharmacies offer preferred cost sharing, and you may pay less when you use them. You can find the list of pharmacies for this plan at **YourMedicareSolutions.com**, or call and we will send you a *Pharmacy Directory*.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you for our share of the cost (see Chapter 5, Section 2 of the *Evidence of Coverage*).

WHERE CAN I LEARN MORE ABOUT ORIGINAL MEDICARE?

The *2026 Medicare & You* handbook explains what Original Medicare covers and the costs you may pay. You can view the handbook online at **Medicare.gov** or call **1-800-MEDICARE (1-800-633-4227)** (TTY: **1-877-486-2048**). You can call 24 hours a day, seven days a week.

WHAT ARE THE BENEFIT STAGES?

As you spend up to certain dollar amounts on your covered prescription drugs, you will move into different benefit stages.

Stage 1: Meet your deductible

The amount you must pay for prescriptions before your plan begins to pay.

Stage 2: Initial coverage

The stage before your total drug costs for the year have reached \$2,100. During this stage you will pay a copayment or coinsurance for your prescriptions.

Stage 3: Catastrophic coverage

This stage begins after your out-of-pocket costs for the year have reached the \$2,100 limit for the calendar year. You will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

USING THE PLAN

UNDERSTANDING YOUR PHARMACY NETWORK AND DRUG TIERS

Using the drug list and the *Pharmacy Directory* will help you get the most out of the plan's benefits.

DRUG COST

- All prescription drugs are placed on one of five tiers, or levels.
- The drug list will tell you which tier your medication is on.
- Whichever tier your drug is on will determine your share of the cost.

THE DRUG TIERS

Cost-sharing tier 1: Preferred generic

This tier is the lowest tier and generally contains the lowest cost generics.

Cost-sharing tier 2: Generic

This tier contains generics.

Cost-sharing tier 3: Preferred brand

This tier contains preferred brand drugs and non-preferred generic drugs.

Cost-sharing tier 4: Non-preferred drug

This tier contains non-preferred brand drugs and non-preferred generic drugs.

Cost-sharing tier 5: Specialty

This tier contains high-cost brand and some generic drugs, which may require special handling and/or close monitoring.



Access the most current drug list at
YourMedicareSolutions.com/Drugs.

NATIONWIDE PHARMACY NETWORK

With thousands of in-network pharmacies throughout the United States, it's convenient and easy to fill your prescriptions. Many offer preferred cost sharing, including independent pharmacies, national chains and more. You will usually pay less for your prescriptions when you use a preferred pharmacy.

LOCATE A PHARMACY

- Pharmacies in the network offer either standard or preferred cost sharing.
- You will usually pay the least amount if you use a pharmacy offering preferred cost sharing.
- Look for pharmacies marked with "SAVE" in the pharmacy directory. These pharmacies offer preferred cost sharing.



Access the most current directory at
YourMedicareSolutions.com/Pharmacy.

A complete list of services is available in the *Evidence of Coverage*. You can access *the Evidence of Coverage* online at **YourMedicareSolutions.com/2026Documents**, or by calling Customer Service to request a copy.

MedicareBlueSM Rx (PDP) is a prescription drug plan with a Medicare contract. Enrollment in MedicareBlue Rx depends on contract renewal.

Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa*; Blue Cross and Blue Shield of Minnesota*; Blue Cross and Blue Shield of Montana*, a division of Health Care Service Corporation, a Mutual Legal Reserve Company; Blue Cross and Blue Shield of Nebraska*; Blue Cross Blue Shield of North Dakota*; Wellmark Blue Cross and Blue Shield of South Dakota*; and Blue Cross Blue Shield of Wyoming*.

* Independent licensee of the Blue Cross and Blue Shield Association.



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IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



MedicareBlue Rx - S5743

For 2026, MedicareBlue Rx - S5743 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.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact MedicareBlue Rx 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 866-434-2037 (toll-free) or 711 (TTY). Current members please call 888-832-0075 (toll-free) or 711 (TTY).

The number of stars show how well a plan performs.

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

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Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment at least 48 hours 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. **Refer to page 2 for product type descriptions.**

Agents must be licensed, contracted and certified, where applicable, to sell each of the plans listed below:

Please INITIAL BELOW in the box beside the type of product(s) you want the agent to discuss:

| | | | |
|--|---------------------------------------|--|--|
| | Medicare Prescription Drug Plan (PDP) | | Ancillary Products |
| | Medicare Advantage Plan(s) | | Medicare Supplement (Medigap) Products |

Beneficiary or Authorized Representative

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 products is either employed or contracted by a Medicare Plan. They do 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 or future enrollment nor will it automatically enroll you in a Medicare plan or any plans discussed.

Beneficiary or authorized representative signature and signature date:

Beneficiary Printed Name

Beneficiary Date of Birth (Optional)

Beneficiary Signature

Date

If you are the **authorized representative**, please sign above and print your name and relationship to the beneficiary

Agent Signature

Date

To be completed by Agent:

| | |
|---|---|
| Agent Name | Agent Phone |
| Beneficiary Address | Beneficiary Phone |
| Initial Method of Contact (indicate if beneficiary walked in) Required | |
| Date Appointment Completed Required | Plans the agent represented during this meeting |



Medicare Plan Descriptions

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-Service plans and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C)

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage.

Preferred Provider Organization (PPO): Require you to use doctors and hospitals in the plan's provider network in order to get the most out of your benefits. Referrals are not needed to see a doctor, specialist or out-of-network provider; however, you will likely have to pay more out of pocket.

Health Maintenance Organization (HMO): HMO plans have a network of doctors and hospitals. Many HMO plans are now open access, where you do not have a primary care physician requirement and may not require a referral to see a specialist. In most HMOs, you can only get care from doctors or hospitals that are in the network (except in emergencies).

Dental/Vision Products

Health Insurance plans offering additional benefits⁴ for consumers who are looking to cover needs for dental or other ancillary products. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Health insurance plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Agents are required to submit a Scope of Appointment form with each Medicare Advantage Plan or Medicare Prescription Drug enrollment application. Scope of Appointment documentation is subject to CMS record retention requirements.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Nebraska Medicare Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

2026 MedicareBlueSM (PDP) Rx Medicare Prescription Drug Plan Individual Enrollment Form

Easy options to enroll



Enroll online at **YourMedicareSolutions.com**



Call **1-866-434-2037**, 8 a.m. to 8 p.m., daily, Central and Mountain times
(TTY: 711)



Contact your licensed sales representative



Fill out the enrollment form and mail to:

MedicareBlue Rx
PO Box 31049
Tampa, FL 33631

Questions? Review the Summary of Benefits included in your 2026 MedicareBlue Rx Enrollment Guide. Or call our Medicare Solutions specialists at the phone number above or your licensed sales representative.

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 on pages 1-5. The items on page 7 are optional — you can't be denied coverage because you don't fill it 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:
MedicareBlue Rx
PO Box 31049
Tampa, FL 33631

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

How do I get help with this form?

Call MedicareBlue Rx Solutions specialists at **1-866-434-2037**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

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 0938-1378) 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.

2026 MedicareBlue Rx Medicare Prescription Drug Plan Individual Enrollment form

Please contact MedicareBlue Rx if you need information in another language or format (braille).

To enroll in MedicareBlue Rx, please provide the following information.

A. Personal information (please print clearly)

Last name:

First name:

Middle initial:

☐ Male ☐ Female

Birth date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| M | M | D | D | Y | Y | Y | Y |

Home phone number:

Alternate phone number (optional):

Email address:

Permanent residence street address (**Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.**):

City:

State:

ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:

City:

State:

ZIP code:

Billing address, if different from your permanent address (P.O. Box allowed):

Street address:

City:

State:

ZIP code:

B. Choose your plan option (for premium information, see your Summary of Benefits)

MedicareBlue Rx: ☐ Standard (001)

C. Please provide your Medicare insurance information

Medicare number:

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D. Paying your plan premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or 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. The amount is usually taken out of your Social Security benefit or you may get a bill from Medicare (or the RRB). Do NOT pay MedicareBlue Rx the Part-D IRMAA.

Electronic funds transfer (EFT) from your bank account each month

It may take up to two months to process your request. Please pay your premiums billed to you on paper until your EFT is active. Any unpaid premiums due when EFT takes effect will be deducted at that time to bring your account up-to-date. You will receive an acknowledgement letter once your information has been reviewed and processed.

Please select a premium payment option:

- ☐ Receive a paper bill. **Do not send a premium payment with this application.**
- ☐ Electronic funds transfer (EFT) from your bank account each month. Please provide the following:


Account holder name: _____

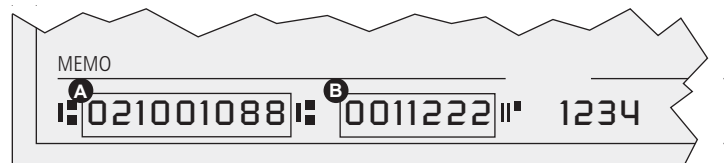
Financial institution: _____


Bank routing number:

Bank account number:

Account type: ☐ Checking ☐ Saving

- A** The bank routing number is nine characters long and appears between the  symbols, usually at the bottom left corner of your check.



- B** Your account number is 5 to 17 characters long and appears next to the  symbol at the bottom of your check, usually to the right of your bank routing number.

- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from:
- ☐ Social Security ☐ RRB

E. Enrollment period determination

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions 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 the box if the statement 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: A choice of effective dates is only allowed in the enrollment situations identified below.** In all other cases, or if you do not specify an effective date, your effective date will be the first of the month after your form is received by the plan.

IF THE STATEMENT YOU SELECT REQUIRES A DATE, PLEASE USE THE FOLLOWING**FORMAT:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

COMMON ENROLLMENT CHOICES:

☐ I am enrolling during the annual enrollment period, October 15 through December 7, for a January 1, 2025, effective date. (Note: the enrollment application must be received by December 7 for the enrollment to be effective on January 1.)

☐ I am new to Medicare. My Medicare Part A effective date is

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 and my Medicare Part B effective date is

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☐ I have had Medicare prior to now, but I am now turning 65.

☐ I am leaving employer or union coverage on the following date:

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. Requested effective date is

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☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) or was notified of the loss (whichever is later). I lost my drug coverage on the following date:

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. Requested effective date is

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☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on the following date:

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| | | | | | | | |
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. Requested effective date is

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 (cannot be before your move date).

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on the following date:

| | | | | | | | |
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.**I HAVE HAD A CHANGE TO MY COVERAGE:**

☐ I have been involuntarily disenrolled from a Medicare Advantage Prescription Drug plan due to loss of Part B but continue to be entitled to Part A as of the following date:

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Enrollee name: _____

OMB No. 0938-1378

Expires: 6/30/2026

- ☐ I am being disenrolled from a special needs plan because my condition does not qualify me for that plan as of the following date:

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- ☐ 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 leaving my Medicare Advantage plan within 12 months of my initial enrollment under a special enrollment period to go back to a Medicare supplement insurance (Medigap) plan as of the following date:

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- ☐ I have disenrolled from a Medicare cost plan and the plan's optional supplemental Part D benefits as of the following date:

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- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on the following date:

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- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on the following date:

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- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I recently left a PACE program on the following date:

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OTHER REASONS:

- ☐ 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.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on the following date:

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- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ I recently obtained lawful presence status in the U.S. I got this status on the following date:

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- ☐ 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 the following date:

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- ☐ 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 government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

☐ I was recently released from incarceration. I was released on the following date:

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☐ Other special enrollment period not identified above. _____

If none of these statements apply to you or you're not sure, please contact our MedicareBlue Rx Medicare Solutions specialists (via the phone number on the front of this form) to see if you are eligible to enroll.

F. Please answer the following questions to help Medicare coordinate your benefits

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

Will you have other **prescription** drug coverage in addition to MedicareBlue Rx? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

G. Please read section H of this enrollment form and sign below

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, including the information in Section H. 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.

Signature: _____ Today's date: _____

☐ I give permission to the licensed agent identified on the next page to enter my enrollment form online through **YourMedicareSolutions.com**.

For authorized representative use only

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

Name (print): _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Relationship to enrollee: _____

☐ I want all mail for this member sent to me.

For agent use only

Agent name (print): _____

National Producer #: _____

Agent #: _____ Agency #: _____

- ☐ Check if you have received this **completed** enrollment form with the enrollee's signature from the enrollee. This paper form must be submitted using one of the methods below within **two (2) calendar days** of the date you receive it. Sign and date below when you receive the form from the beneficiary.

Agent signature: _____

Date form received: _____ Phone number: _____

Check selected submission method and enter information as appropriate:

☐ Paper to online application. Enter online confirmation number: _____

☐ Application faxed. Enter date faxed (keep fax confirmation sheet): _____

☐ Application sent overnight. Be sure to keep the overnight receipt.

H. Enrollment authorization: By completing this enrollment application, I agree to the following

After carefully reading the statements in this section, please sign Section G of this form.

1. I must keep Part A or Part B to stay in MedicareBlue Rx.
2. By joining this Medicare prescription drug plan, I acknowledge that MedicareBlue Rx 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 on page 6).
3. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
4. 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.
5. 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.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

All items on this page are optional.

Answering the following questions is your choice. You can't be denied coverage because you don't fill it out.

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact MedicareBlue Rx at **1-866-434-2037** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., daily, Central and Mountain times. TTY users can call **711**.

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

List your Primary Care Physician (PCP), clinic, or health center: _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

If you need more information



Visit **YourMedicareSolutions.com**



Call **1-866-434-2037**, 8 a.m. to 8 p.m., daily, Central and Mountain times
(TTY: 711)



Contact your licensed sales representative

MedicareBlueSM Rx (PDP) is a prescription drug plan with a Medicare contract. Enrollment in MedicareBlue Rx depends on contract renewal.

Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa*; Blue Cross and Blue Shield of Minnesota*; Blue Cross and Blue Shield of Montana*, a division of Health Care Service Corporation, a Mutual Legal Reserve Company; Blue Cross and Blue Shield of Nebraska*; Blue Cross Blue Shield of North Dakota*; Wellmark Blue Cross and Blue Shield of South Dakota*; and Blue Cross Blue Shield of Wyoming*.

*Independent licensees of the Blue Cross and Blue Shield Association



MedicareBlueSM Rx (PDP)
A Medicare Prescription Drug Plan

RAS1018R19 (08/25)

Notice of Availability

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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 quý vị cần thông dịch viên xin gọi 1-866-434-2037 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-434-2037 (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 1-866-434- 2037 (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 1-866-434-2037 (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 (TTY: 711) 1-866-434-2037. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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 1-866-434-2037 (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。通訳をご用命になるには、1-866-434-2037 (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。

NOTES



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* Independent licensee of the Blue Cross and Blue Shield Association.

A complete list of services is available in the *Evidence of Coverage*. You can access the *Evidence of Coverage* online at **YourMedicareSolutions.com**, or by calling customer service to request a copy.