

NaviCare[®]* Pre-Enrollment Checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to an Enrollee Services representative at 1-877-255-7108 (TTY 711), 8 a.m. to 8 p.m., Monday through Friday (7 days a week, Oct. 1 through March 31).

Understanding the benefits

- ☐ The Member Handbook provides a complete list of all coverage and services. It's important to review plan coverage, costs, and benefits before you enroll. Visit fallonhealth.org/navicare or call 1-877-255-7108 (TTY 711) to view or request a copy of the Member Handbook.
- ☐ Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they're not listed, it means you'll likely have to select a new doctor.
- ☐ Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy isn't listed, you'll 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, 2028.
- ☐ You must continue to pay your Medicare Part B premium unless the Commonwealth of Massachusetts pays this premium for you. This premium is normally taken out of your Social Security check each month.
- ☐ Except in emergency or urgent situations, we don't cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on the following: 1) You must be age 65 or older, 2) You must have MassHealth Standard and Medicare Parts A and B, 3) You must live in the service area (all of MA, except Dukes and Nantucket counties), 4) You can't have any other comprehensive health insurance except Medicare.
- ☐ Effect on current coverage. If you're currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you'll be paying for coverage you cannot use.



* NaviCare HMO SNP and NaviCare NHC HMO SNP

Which NaviCare[®] plan should I choose?

Fallon Health offers 2 NaviCare plans:

1. NaviCare HMO SNP
2. NaviCare NHC HMO SNP

You'll qualify for 1 plan only. Review each section of this form. After you have checked the items that apply to you, you'll learn which plan to choose on the enrollment form.

Section 1.

To join either NaviCare plan, you must:

- ☐ Be age 65 or older
- ☐ Live in the service area
(All cities/towns in Massachusetts, except those in Dukes and Nantucket counties)
- ☐ Have MassHealth Standard
- ☐ Have Medicare Parts A and B
- ☐ Not have other health insurance except Medicare

If you checked all the above boxes, continue to Section 2. If you didn't check all the boxes, please call us. We can help find a plan that you can join.

Section 2.

Place a checkmark next to all items on the list below that apply to you.

Daily nursing needs I need help every day with ...	
☐ Caring for a wound	☐ Getting/taking shots or injections
☐ Caring for a catheter	☐ Getting medicine through an IV
☐ Caring for an ostomy bag	☐ Feeding through a tube
☐ Using oxygen	

Section 3.

Place a checkmark next to all items in each list below that apply to you.

Nursing services I need help at least 3 times per week with ...	
☐ Taking medicine by mouth, and/or managing medications and refills	☐ Changing positions while in a chair or bed
☐ Checking blood pressure or other important health signs	☐ Staying safe, avoiding dangerous situations, getting lost or confused about where I am
☐ Tracking how much I drink, urinate, or use the bathroom	☐ Changing bandages, caring for wounds
	☐ Therapy that helps me move or communicate

Activities of daily living I need help every day with ...	
☐ Bathing	☐ Walking or moving around in a wheelchair by myself
☐ Getting dressed	☐ Using the bathroom, managing accidents or managing bladder/bowel problems
☐ Eating	
☐ Moving from a bed to a chair	

Which plan do I choose on the enrollment form?

Choose **NaviCare NHC HMO SNP** if:

You selected **all the items in Section 1 and:**

- ☐ Checked any item in Section 2, **OR**
- ☐ Checked at least 1 item under Nursing services in Section 3, and at least 2 more items from either list in Section 3

Choose **NaviCare HMO SNP** if:

You selected **all the items in Section 1 and:**

- ☐ Did not check any items in Section 2, **AND**
- ☐ Did not check any items from the Nursing services list in Section 3

No matter which plan you join, you'll get the same benefits and healthy extras that help you save money. You'll also pay \$0 for copays, deductibles, and your monthly premium!

Not sure which plan to choose? Call us. We're happy to help.

1-877-255-7108 (TTY 711)

8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)



PLEASE SUBMIT THIS FORM WITH THE NAVICARE ENROLLMENT FORM

NaviCare HMO SNP/NaviCare NHC HMO SNP is a Dual Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Commonwealth of Massachusetts MassHealth (Medicaid) program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare and does not have any other comprehensive health insurance, except Medicare.



This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in _____ NaviCare®.



MassHealth Senior Care Options (SCO) & Medicare Advantage Enrollment Form

► Select the plan you want to join ☐ NaviCare® HMO SNP ☐ NaviCare® NHC HMO SNP

MassHealth Information

► Are you enrolled in MassHealth? Yes ☐ No ☐

Please write in your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name. MassHealth ID number: _____

You must be 65 years or older, have MassHealth Standard and Medicare Parts A and B benefits, live in the _____ NaviCare _____ service area, not have other comprehensive health insurance (except Medicare) and not be a resident of a chronic hospital, to enroll in a senior care organization. To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

► Name of primary care doctor you have selected: _____

Member Information

Last name		First name		MI	Mr. ☐ Mrs. ☐ Ms. ☐
Date of birth	Preferred format for materials ☐ Braille ☐ Large print ☐ Audio CD* ☐ Data CD ☐ Other _____				
*Audio messages will not be encrypted, which means they could be intercepted by others. By selecting audio, you agree to receive these audio messages without encryption.					
Sex M ☐ F ☐	Written language preferred		Spoken language preferred		

Permanent address (where you live)

Street address		City/town	
State	ZIP	Home phone number	
Mobile phone number (optional) (_____) _____ - _____		Email address (optional) _____	
☐ I authorize Fallon Health to send me text messages related to my plan benefits and services.		☐ I authorize Fallon Health to send me email messages related to my plan benefits and services.	

Mailing address (where you get mail, if different from where you live)

Street address		City/town
State	ZIP	Telephone number

If you are a resident of a **nursing facility**, enter the name and address here.

Name of nursing facility		
Street address		City/town
State	ZIP	Telephone number

Medicare Information

► Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):

Medicare Number:

Is entitled to:

Effective date:

☐ HOSPITAL (Part A) _____

☐ MEDICAL (Part B) _____

Other Health Insurance

► Do you have any health insurance other than Medicare and MassHealth? Yes ☐ No ☐

If you answered yes, what is the name of the other insurance? _____

Your Medical Care

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

NaviCare HMO SNP/NaviCare NHC HMO SNP is a Dual Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Commonwealth of Massachusetts MassHealth (Medicaid) program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare and does not have any other comprehensive health insurance, except Medicare. I will need to keep my MassHealth Standard and my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Because I have MassHealth and Medicare Parts A and B, I may leave _____ NaviCare _____ any time. I will no longer be covered by _____ NaviCare _____ on the first day of the month following the month I request to leave _____ NaviCare _____. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

_____ NaviCare _____ serves a specific service area. If I move out of the area that _____ NaviCare _____ serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of _____ NaviCare _____, I have the right to appeal plan decisions about payment or services if I disagree with them. I will read the Member Handbook from _____ NaviCare _____ when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date that _____ NaviCare _____ coverage begins, I must get all my health care from _____ NaviCare _____ with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by _____ NaviCare _____ and other services contained in my _____ NaviCare _____ Member Handbook document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR _____ NAVICARE _____ WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with _____ NaviCare _____, he or she may be compensated based on my enrollment in _____ NaviCare _____.

Release of Information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that _____ NaviCare _____ will release my information to Medicare, who may release it for research and other purposes that 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 behalf of the individual under the laws of the state where the individual resides) 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 _____ NaviCare _____ or by Medicare.

One of our Enrollee Service Representatives will be calling you within the next 10 days to verify the information on this form and to make sure you understand our plan rules.

Please provide a telephone number we may use for that call: _____

Best time to call: _____ *morning* _____ *afternoon* _____ *evening*

Signature

Signature: _____

Print name: _____

Today's date: _____

If you have chosen an authorized representative, the authorized representative must sign above and provide the following information.

Name: _____

Address: _____

Primary phone number: _____

Relationship to enrollee: _____

Office Use Only

Date received: _____

Name of staff member/agent/broker (*if assisted in enrollment*):

Broker/agent name: _____ Mass. Lic#: _____

National Producer Number (brokers/agents only): _____

Plan ID No: _____

Effective date of coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____

SEP (type): _____ Not Eligible: _____

Notes
