MARYLAND SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM ENROLLMENT APPLICATION

Dear Applicant:

The Maryland Senior Prescription Drug Assistance Program (SPDAP) is pleased to provide you with the enclosed application for state assistance with your Medicare prescription drug coverage premiums and coverage gap costs. SPDAP premium subsidies are available to Maryland Medicare recipients, including those under age 65, who:

- are enrolled in a Medicare Rx prescription drug plan or a Medicare Advantage Plan;
- are not eligible for full federal "Extra Help" as determined by the Social Security Administration; AND
- have a household income at or below 300 percent of federal income standards.

Qualified applicants can receive up to $40 per month towards the cost of their monthly Medicare Rx or Medicare Advantage Prescription drug premiums.

Qualified applicants whose drug costs exceed $2,960 in 2015 may be eligible for the SPDAP Coverage Gap subsidy. To be eligible for the SPDAP Coverage Gap ("Doughnut Hole") subsidy you must be enrolled in one of the Medicare Rx prescription drug plans or Medicare Advantage Plans that has agreed to administer the SPDAP Coverage Gap subsidy (see the attached lists of "SPDAP Participating Prescription Drug Plans"). If the plan you have elected to enroll in is one of the plans that is administering the SPDAP Coverage Gap subsidy your prescription costs during the coverage gap or "doughnut hole" will be a 5% co-insurance on the total prescription cost. The remaining costs of your prescriptions will be covered by any supplemental coverage offered by your plan, any applicable Federal Drug Discount, with the remainder being paid by SPDAP. (see example below).

Example of How Coverage Gap Subsidy Is Determined - 2015		
Prescriptions in the Coverage Gap ('Doughnut Hole")	**Brand Name Drug**	**Generic Drug**
Total Cost of Prescription	$ 100.00	$ 20.00
Less: Plan Supplemental Coverage – if applicable	$ -	$ -
Less: Federal Drug Discount - 2015	$ 55.00	$ 7.00
Member's prescription Cost prior to SPDAP Coverage Gap Subsidy	$ 45.00	$ 13.00
Less: SPDAP Member's 5% Co-Insurance **(Total Cost to Member)**	$ 5.00	$ 1.00
Remainder of Prescription Cost (Subsidized by SPDAP)	$ 40.00	$ 12.00

If you have not done so already, you **must** enroll in a Medicare Rx prescription drug plan or a Medicare Advantage Plan to receive the premium subsidy of up to $40 per month and, if eligible, the "doughnut hole" subsidy. A list of Medicare Rx prescription drug plans and Medicare Advantage Plans that are available in the State is included on the next two pages.

If you are approved in SPDAP, we will notify Medicare of your membership in the program. Medicare will then advise us of the Medicare Rx prescription drug plan or Medicare Advantage Plan in which you are enrolled. This process may take 60 to 90 days. If you wait to enroll in a drug plan, the process will take longer.

Once Medicare informs us of the Medicare Rx prescription drug plan or Medicare Advantage Plan in which you are enrolled, we will pay up to $40 for each month after your effective date with SPDAP.

DO NOT have your Medicare Rx premium automatically deducted from your Social Security check. If you are currently having your premium deducted from your Social Security Check, contact your Prescription Drug Plan and request direct billing.

PLEASE NOTE: SENDING AN INCOMPLETE APPLICATION OR NOT ENCLOSING THE REQUIRED DOCUMENTATION MAY RESULT IN A DELAY AND REDUCTION IN THE AMOUNT OF SPDAP SUBSIDES YOU RECEIVE THIS YEAR

If you need additional information, please call the SPDAP call center at 1-800-551-5995 or visit our website at www.marylandspdap.com.

Sincerely,
Maryland Senior Prescription Drug Assistance Program

2015 SPDAP Participating Prescription Drug Plans

Plan Name	Company Name	Monthly Premium beforeSPDAP Assistance	Maryland SPDAP "Doughnut Hole" Subsidy Offered & Member Cost Sharing during Subsidy
Stand Alone Prescription Drug Plans Offering SPDAP Coverage Gap and the $40 Monthly Premium Subsidies			
First Health Part D Premier Plus (PDP)	First Health Part D	$94.60	Yes, 5% coinsurance
Stand Alone Prescription Drug Plans with ONLY the SPDAP $40 Monthly Premium Subsidy			
Aetna Medicare Rx Saver (PDP)	Aetna Medicare	$25.30	No
Aetna Medicare Rx Premier (PDP)	Aetna Medicare	$120.00	No
Cigna-HealthSpring Rx Secure (PDP)	Cigna-HealthSpring Rx	$30.90	No
Cigna-HealthSpring Rx Secure-Max (PDP)	Cigna-HealthSpring Rx	$127.10	No
Cigna-HealthSpring Rx Secure-Xtra (PDP)	Cigna-HealthSpring Rx	$35.80	No
EnvisionRxPlus Silver (PDP)	EnvisionRx Plus	$30.80	No
SmartD Rx Saver (PDP)	Express Scripts Medicare	$28.60	No
Express Scripts Medicare - Value (PDP)	Express Scripts Medicare	$31.20	No
Express Scripts Medicare - Choice (PDP)	Express Scripts Medicare	$56.00	No
First Health Part D Value Plus (PDP)	First Health Part D	$37.60	No
Humana Enhanced (PDP)	Humana Insurance Company	$55.60	No
Humana Preferred Rx Plan (PDP)	Humana Insurance Company	$29.00	No
Humana Walmart Rx Plan (PDP)	Humana Insurance Company	$15.70	No
SilverScript Choice (PDP)	SilverScript	$26.00	No
SilverScript Plus (PDP)	SilverScript	$85.30	No
Transamerica MedicareRx Classic (PDP)	Stonebridge Life Insurance Company	$29.40	No
Transamerica MedicareRx Choice (PDP)	Stonebridge Life Insurance Company	$40.10	No
Symphonix Rite Aid Value Rx (PDP)	Symphonix Health	$30.40	No
Symphonix Rite Aid Premier Rx (PDP)	Symphonix Health	$90.80	No
United American - Enhanced (PDP)	United American Insurance Company	$68.20	No
United American - Select (PDP)	United American Insurance Company	$34.30	No
United American - Essential (PDP)	United American Insurance Company	$23.70	No
AARP MedicareRx Preferred (PDP)	UnitedHealthcare	$46.50	No
AARP MedicareRx Saver Plus (PDP)	UnitedHealthcare	$28.40	No
WellCare Classic (PDP)	WellCare	$32.80	No
WellCare Extra (PDP)	WellCare	$55.80	No

2015 SPDAP Participating Prescription Drug Plans

Plan Name	Company Name	Monthly Premium before SPDAP Assistance	Maryland SPDAP "Doughnut Hole" Subsidy Offered & Member Cost Sharing during Subsidy
Medicare Advantage Plans Offering SPDAP Coverage Gap and the $40 Monthly Premium Subsidies			
Cigna-HealthSpring Traditions	Cigna-HealthSpring	$30.60	Yes, 5% coinsurance
Cigna-HealthSpring Preferred (Plan 022)	Cigna-HealthSpring	$8.00	Yes, 5% coinsurance
Cigna-HealthSpring Preferred (Plan 028)	Cigna-HealthSpring	$26.00	Yes, 5% coinsurance
Cigna-HealthSpring Achieve (Plan 029)	Cigna-HealthSpring	$36.90	Yes, 5% coinsurance
Cigna-HealthSpring Achieve (Plan 030)	Cigna-HealthSpring	$26.80	Yes, 5% coinsurance
Cigna-HealthSpring PreventiveCare	Cigna-HealthSpring	$0.00	Yes, 5% coinsurance
Medicare Advantage Prescription Drug Plans with ONLY the SPDAP $40 Monthly Premium Subsidy			
Aetna Medicare Standard Plan (HMO)	Aetna Medicare	$13.70	No
Erickson Advantage Signature with Drugs (HMO-POS)	Erickson Advantage	$2.40	No
Erickson Advantage Guardian (HMO-POS SNP)	Erickson Advantage	$2.90	No
Erickson Advantage Champion (HMO-POS SNP)	Erickson Advantage	$0.00	No
Erickson Advantage Freedom (HMO-POS)	Erickson Advantage	$0.00	No
HumanaChoice H6609-103 (PPO)	Humana Insurance Company	$24.30	No
Kaiser Permanente Medicare Plus High w/Part D (AB) (Cost)	Kaiser Permanente	$49.70	No
Kaiser Permanente Medicare Plus Std w/Part D (AB) (Cost)	Kaiser Permanente	$2.00	No
Kaiser Permanente Medicare Plus Std w/Part D (B) (Cost)	Kaiser Permanente	$33.30	No
MedStar Medicare Choice (HMO	MedStar Family Choice, Inc	$0.00	No
MedStar Medicare Choice Care Advantage (HMO SNP)	MedStar Family Choice, Inc	$0.00	No
UnitedHealthcare Nursing Home Plan (PPO SNP)	UnitedHealthcare	$30.60	No

INSTRUCTIONS

If both you and your spouse wish to apply for Maryland SPDAP, both you and your spouse must complete **separate** individual applications. **Couples cannot submit a joint application.**

1. Complete the enclosed application. Answer all applicable questions. Be sure to have your red, white and blue Medicare identification card available. You will need this card to complete section I, question 2, Medicare information.

2. Attach proof of at least six months of Maryland residency. **The document(s) you submit must prove at least six months of Maryland residency.** For example: If you submit a Maryland driver's license, the issuance date must be at least six months before the date of this application. If the issuance date on your driver's license is less than six months before the date of this application, you can submit another form of proof of residency such as a six-month old utility bill or telephone bill. Copies of the following are acceptable:
   - **Maryland driver's license** which is dated to show 6 months of Maryland residency
   - **State identification card** which is dated to show 6 months of Maryland residency
   - **Recent state tax form** which is dated to show 6 months of Maryland residency
   - **Voter registration card** which is dated to show 6 months of Maryland residency
   - **Rental agreement** which is dated to show 6 months of Maryland residency
   - **Property tax bill** which is dated to show 6 months of Maryland residency
   - **Utility bill** which is dated to show 6 months of Maryland residency

3. Attach a copy of your most recent federal income tax return. (Do not include schedules and other attachments). If you did not file a federal income tax return, you must provide us with documentation, such as a copy of a benefit statement, for each of the following types of income that you received during the last year:
   - Social Security retirement benefits or Railroad Retirement benefits;
   - Pension, annuity, Civil Service annuity, or other retirement income;
   - Wages;
   - Dividends, interest earnings, or capital gains; and
   - Distributions and withdrawals from an Individual Retirement Account (IRA), 401(k), 403(b), 457(b), or Simplified Employee Pension plan (SEP).

4. Sign the application. If you are married and live with your spouse, both you and your spouse must sign the application.

5. Make copies of your application and all other documents for your records.

6. Return the application to:

Maryland SPDAP
c/o Pool Administrators
628 Hebron Avenue
Suite 100
Glastonbury, CT 06033

SECTION I

1. PERSONAL INFORMATION (Please Print)

Name (as it appears on Medicare Card)

_____ _____ _____
Last First MI

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____

Social Security Number _____

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single

Spouse Name

_____ _____ _____ Date of Birth: _____/____/_____
Last First MI

Home
Address:_____

City: _____ State: _____ Zip Code_____

Mailing Address (if different from home address) _____

City: _____ State: _____ Zip Code_____

Home Phone Number (_____) _____

How long have you been a resident of the state of Maryland? _____

2. MEDICARE INFORMATION (Please Print)

Are you covered by Medicare? ☐ Yes ☐ No

Complete the following using the Medicare Information **as printed on your red, white and blue Medicare Identification card. <u>Your Medicare Number should include nine numbers and at least one letter</u>.**

MEDICARE NUMBER	MEDICARE (PART A) EFFECTIVE DATE:	MEDICARE (PART B) EFFECTIVE DATE:
	_____/_____/_____ mm dd yyyy	_____/_____/_____ mm dd yyyy

SECTION II

1. Please indicate the number of members of your household by checking the appropriate box. To determine the number of members of your household, you should count only the following:
   - yourself;
   - your spouse, if your spouse resides in the same residence as you; and
   - any individual who is related to you by blood, marriage, or adoption; resides in the same residence as you; and is dependent on you or your spouse for at least one-half of the individual's support.

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9 or more**

2. Is your total household income at or below the SPDAP income eligibility level as shown in the chart below?

☐ Yes ☐ No

SPDAP Income Eligibility Chart		
1 Person	$ 35,010	***Household Income*** means the earned and unearned income of the applicant and spouse who reside in the same residence. If you filed a federal income tax return, household income includes both taxable and non-taxable income (i.e. Social Security, etc…). You may use the worksheet on the following page to help you calculate your total household income for the current year.
2 People	$ 47,190	
3 People	$ 59,370	
4 People	$ 71,550	
5 People	$ 83,730	
6 People	$ 95,910	
7 People	$ 108,090	
8 People	$ 120,270	

3. Did you file a federal income tax return for the previous year? ☐ Yes ☐ No

If you answered "Yes" to question 3, attach your most recent federal income tax return and proceed to question 4.

If you answered "No" to question 3, complete the following income worksheet and attach documentation, such as a copy of a benefit statement, for each of the following types of income that you received during the past year:

- Social Security retirement benefits or Railroad Retirement benefits;
- Pension, annuity, Civil Service annuity, or other retirement income;
- Wages;
- Dividends, interest earnings, or capital gains; and
- Distributions and withdrawals from an Individual Retirement Account (IRA), 401(k), 403(b), 457(b), or Simplified Employee Pension plan (SEP).

HOUSEHOLD INCOME DETERMINATION SHEET				
Type of Income (Annual amount before taxes and other deductions)	**Applicant**	**Spouse**	**Other Household Members**	**Total**
Total Social Security Retirement Benefit Income	$	$	$	$
Total Social Security Disability Benefit Income	$	$	$	$
Supplemental Security Income (SSI)	$	$	$	$
Veterans' Benefits	$	$	$	$
Railroad Retirement	$	$	$	$
Civil Service Annuity	$	$	$	$
Pension, Retirement, or Disability Income	$	$	$	$
Rental Income	$	$	$	$
Dividends or Interest Earnings	$	$	$	$
Wages	$	$	$	$
Alimony	$	$	$	$
Self Employment Income	$	$	$	$
Unemployment	$	$	$	$
Workers' Compensation	$	$	$	$
Annuity Income	$	$	$	$
Capital Gains	$	$	$	$
Distributions and withdrawals from Individual Retirement Accounts (IRA) , 401(k), 403(b), 457(b) , Simplified Employee Pension plans (SEP – 408(k)) - ***do not include rollovers***	$	$	$	$
Other	$	$	$	$
TOTAL INCOME FOR THIS YEAR	$	$	$	$

4. Do you have any prescription drug coverage other than the coverage provided by your Medicare Part D prescription drug plan or Medicare Advantage Plan? (Do not include prescription drug discount cards or drug benefits provided by the Veterans Administration.)

☐ Yes ☐ No

5. Have you applied to the Social Security Administration for "Extra Help" for your Medicare Rx prescription drug costs?

☐ Yes ☐ No

If yes, were you: ☐ Approved ☐ Denied ☐ Pending

SECTION III

YOU MUST ANSWER QUESTION 1 FOR YOUR APPLICATION TO BE COMPLETE.

1. If you are single, divorced, a widow(er) or your spouse does not live with you, are your savings, investments and real estate (other than your primary residence) worth more than $13,440.00? Include the things you own by yourself or with someone else. **Do not include your primary residence, vehicles, burial plots or personal possessions.**

   ☐ Yes ☐ No ☐ Not Sure

   If you are married and living with your spouse, are your savings, investments and real estate (other than your primary residence) worth more than $26,860.00? Include the things you own by yourself, with your spouse or with someone else. **Do not include your primary residence, vehicles, personal possessions, burial plots, life insurance, irrevocable burial contracts or back payments from Social Security or SSI.**

   ☐ Yes ☐ No ☐ Not Sure

If you answered "YES" to question 1, please move on to Section IV on page 12 of this application.

If you answered "**NO**" or "**NOT SURE**" **to question 1**, **then you must complete the following questions to allow us to determine your eligibility for both federal and state subsidies of your prescription drug coverage.** This information will be used to submit an application on your behalf to the Social Security Administration for "Extra Help" from the federal government that would further reduce your premiums and prescription drug co-pays. This federal "Extra Help" is the most comprehensive coverage available to Medicare Rx members, and it is in your best interest to apply for it.

2. In the boxes below, enter the dollar amount of bank accounts, investments and cash that are owned by you. If you are married and live with your spouse, include the dollar amount of bank accounts, investments and cash that are owned by your spouse or by both of you. Include items that either of you own with another person. Include only the dollar figures, not the account number.

		Total Amount
Bank accounts (checking, savings and certificates of deposit)	☐ **NONE**	$
Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	☐ **NONE**	$
Any other cash at home or anywhere else	☐ **NONE**	$

3. Do you expect to use money from any of the sources listed in question 2 to pay for funeral or burial expenses for yourself or your spouse (if living together)?

YOU: ☐ Yes ☐ No
SPOUSE (if living together): ☐ Yes ☐ No

4. Other than your home and the property on which it is located, do you own any real estate? If you are married and live with your spouse, does your spouse own any real estate?

YOU: ☐ Yes ☐ No
SPOUSE (if living together): ☐ Yes ☐ No

5. If you receive income from any of the sources listed below, please enter the total MONTHLY income. If you are married and live with your spouse, include any income that your spouse receives from any of the sources listed below. If the amount changes from month to month, enter the average MONTHLY income for the past year. Do not list wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here.

		Monthly Income
Social Security	☐ NONE	$
Railroad Retirement	☐ NONE	$
Veterans	☐ NONE	$
Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	☐ NONE	$
Other income not listed above, including alimony, net rental income, workers' compensation (Specify):_____	☐ NONE	$

6. Have any of the amounts you included in question 5 decreased during the last two years?

   ☐ Yes ☐ No

7. Have you worked in the last two (2) years? If you are married and live with your spouse, has your spouse worked in the last two (2) years?

   YOU: ☐ Yes ☐ No

   SPOUSE (if living together): ☐ Yes ☐ No

8. If you are married, please provide your SPOUSE'S Social Security Number:

   _____

If you answered "Yes" to question 7 for either you or your spouse, you must answer questions 9 through 12. If not, skip to question 13.

9. What do you expect to earn in wages before taxes **this year**?

YOU: ☐ NONE $_____

SPOUSE (if living together): ☐ NONE $_____

10. If self-employed, what do you expect your net earnings or losses to be this year?

YOU: ☐ NONE $_____

SPOUSE (if living together): ☐ NONE $_____

Put an X here ☐ if you or your spouse (if living together) expect a net loss.

11. Have the amounts you included in questions 9or 10 decreased in the last two years?

☐ Yes ☐ No

12. If you or your spouse (if living together) recently stopped working or plan to stop working, enter the month and year.

YOU _____/_____
Month Year

SPOUSE (if living together): _____/_____
Month Year

<u>If you are younger than age 65</u>, you must answer question 13 below. Otherwise, sign the application on page 12 and return it to us.

13. Do you or your spouse (if living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression, or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU: ☐ Yes ☐ No

SPOUSE (if living together): ☐ Yes ☐ No

SECTION IV

I understand that by submitting this application I am declaring under penalty of perjury that I have examined all the information on this application and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. I certify that my answer in Section II, No. 1 above, regarding my household income, is also true and correctly recorded. These statements are relied on to determine my eligibility for the Maryland Senior Prescription Drug Assistance Program. I authorize the Maryland Senior Prescription Drug Assistance Program, and its administrator POOL ADMINISTRATORS INC., to apply on my behalf for "Extra Help" with my prescription drug costs by submitting the information provided in this application to the Social Security Administration (SSA). I understand that the Social Security Administration will check my statements and compare its records with records from federal, state and local government agencies, including the Internal Revenue Service, to make sure the determination is correct. By submitting this application I am authorizing SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions.

Please sign and date the application.
This application is not complete unless signed and dated.

_____**Date**_____/_____/_____
Applicant's Signature or Authorized Representative's Signature

_____**Date**_____/_____/_____
Spouse's Signature

_____
Applicant's Name - PLEASE PRINT

If the individual signing the application is an authorized representative, please check here ☐
(Include a copy of your Power of Attorney Form, or call SPDAP for an Authorized Personal Representative Form @ 1-800-551-5995)

Please indicate your relationship to applicant_____

Authorized Representative's phone number _____

REMINDER:

Please attach proof of six months of Maryland residency for all SPDAP applicants, such as a copy of your driver's license or state ID card, voter registration form or utility bill dating back six months.

Please attach a copy of your most recent federal income tax return. (Do not include schedules and other attachments). If you did not file a federal income tax return, attach documentation, such as a copy of a benefit statement, for each of the following types of income that you received during the past year: Social Security retirement benefits or Railroad Retirement benefits; pension, annuity, Civil Service annuity, or other retirement income; wages; dividends, interest earnings, or capital gains; and distributions and withdrawals from an IRA, 401(k), 403(b), 457(b), or SEP.