



Brandman
HEALTH PLAN



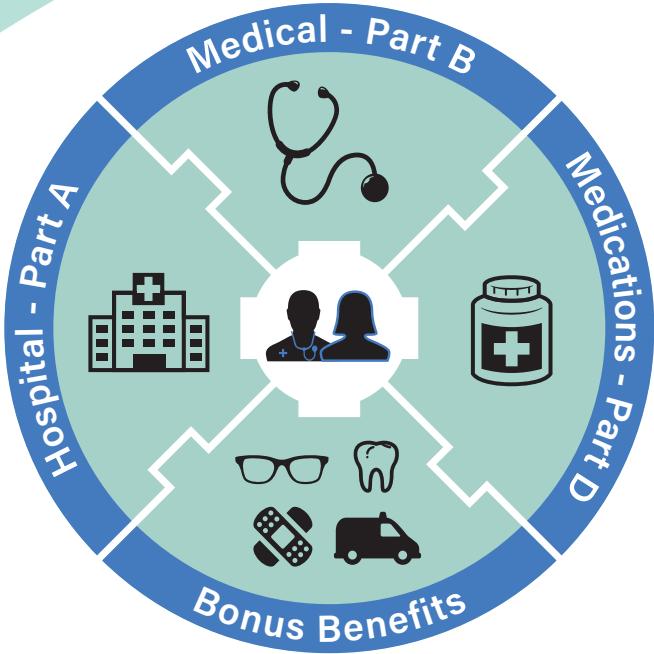
**2021
SUMMARY
OF BENEFITS**

Brandman Health Plan Aspire-D (HMO C-SNP)

H7594_20BHP_AspireDSB2021_M File & Use 10/06/2020

**CALIFORNIA:
Los Angeles County**

All-in-One Health Coverage



The Care You Need. The Value You Expect.

Complex health conditions like yours can create many challenges. Getting the healthcare you need shouldn't be one of them. That's why Brandman Health Plan (HMO SNP) created a Medicare Advantage plan just for people with dementia. Meet Aspire-D (HMO C-SNP), the new health plan from Brandman that makes it easier to get the care you need! It's an **ALL-IN-ONE** solution for your healthcare coverage. It combines three types of Medicare coverage into one plan: Part A (hospital), Part B (doctors), and Part D (drugs). Also, it gives you additional benefits that Original Medicare doesn't, such as:

- ✓ \$0 Dentures
- ✓ \$0 Eyewear (up to \$250 value)
- ✓ \$0 Hearing aids (up to \$1000 value)

Save On Insulins With Our Senior Savings Program

If you have diabetes managed with insulin, check out our Senior Savings Program. It's an easy way to save and have your 90-day prescription delivered to you!

Do I Qualify?

In order to join Brandman Health Plan Aspire-D (HMO C-SNP) you must:

- Be diagnosed with dementia
- Have both Medicare Part A and B
- Live in Los Angeles County
- Be a U.S. citizen or lawfully present in the country

For questions or to learn more, call Member Services today!



**Brandman
HEALTH PLAN**

1-888-697-5662

Premiums and Benefits	Coverage Details	What you should know
Monthly Plan Premium	You pay \$31.50 for your Part D premium.	You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible for Part C.	Applies to services you get in-network or out-of-network.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	The most you will pay each year for Part C services in this plan is \$7,550.	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage	<ul style="list-style-type: none"> ▪ You pay \$0 per day for days 1 - 60. ▪ You pay \$352 per day for days 61 - 90. ▪ Our plan provides a maximum of 60 Lifetime Reserve days. You pay a \$704 copay per day for days 1 - 60. ▪ These are the amounts for 2020 and may change in 2021. The plan will let you know once Medicare announces these amounts for 2021. 	Referral and authorization are required.
Outpatient Hospital Coverage	You pay 20% of the cost.	Includes services received in an ambulatory surgical center or outpatient hospital. Referral and prior authorization are required.
Doctor Visits	You pay 20% of the total cost for each primary care physician or specialist visit. In-person and telehealth options are available.	Referral and authorization are required for specialist visits.
Preventive Care	You pay \$0.	Prior authorization may be required.
Emergency Care	You pay 20% of the cost.	
Urgently Needed Services	You pay \$0.	
Diagnostic Services/ Labs/Imaging <ul style="list-style-type: none"> ▪ Diagnostic radiology service (e.g., MRI) ▪ Lab services ▪ Diagnostic tests and procedures ▪ Outpatient x-rays 	You pay 20% of the cost.	Referral and prior authorization are required.

Premiums and Benefits	Coverage Details	What you should know
Hearing Exams	<ul style="list-style-type: none"> ▪ Medicare-covered Diagnostic exams: You pay 20%. ▪ Routine hearing exam: You pay \$0. ▪ Hearing aid allowance: You pay \$0. The plan covers up to \$1,000 per calendar year. 	The plan covers 1 exam per year. Hearing aid allowance is for both ears combined.
Dental Services <ul style="list-style-type: none"> - Exam & Cleaning (every 6 months) - Comprehensive Dental (e.g. fillings and dentures) 	<ul style="list-style-type: none"> ▪ Medicare-covered Dental services: You pay \$0. ▪ Preventive dental services: You pay 20% ▪ Comprehensive dental services: You pay \$0 	The plan covers up to \$750/year in dental services.
Vision Services <ul style="list-style-type: none"> - Exams (1 per year) - Glasses or Contacts (1 every two years) 	<ul style="list-style-type: none"> ▪ Medicare-covered Vision services: You pay \$0. ▪ You pay \$0 for routine eye exams. ▪ You pay \$0 for either: <ul style="list-style-type: none"> ▪ One pair of eyeglasses (lenses and frames) ▪ One pair of contact lenses 	The plan covers up to \$250 every two years towards lenses and frames or contacts.
Mental Health Services <ul style="list-style-type: none"> - Inpatient visit - Outpatient therapy visit (group or individual) 	<ul style="list-style-type: none"> ▪ Inpatient Visit: <ul style="list-style-type: none"> ▪ You pay \$0 per day for days 1-60. ▪ You pay \$329 per day for days 61 - 90. ▪ Our plan provides a maximum of 60 Lifetime Reserve days. You pay a \$704 copay per day for days 1 – 60. This is the amount for 2020 and may change in 2021. The plan will let you know once Medicare announces these amounts for 2021. ▪ Outpatient services: <ul style="list-style-type: none"> ▪ You pay 20% of the total cost. 	Referral and prior authorization may be required. Contact the plan for more information.
Skilled Nursing Facility	We cover up to 100 days in a SNF per benefit period: <ul style="list-style-type: none"> ▪ You pay \$0 per day for days 1 – 20. ▪ You pay \$176 per day for days 21 – 100. ▪ These are the amounts for 2020 and may change in 2021. The plan will let you know once Medicare announces these amounts for 2021. 	Referral and prior authorization are required.
Physical Therapy	You pay 20% of the cost.	Referral and prior authorization are required.
Ambulance	You pay 20% of the cost for each trip by ground or air.	Prior authorization is required for non-emergency trips.
Transportation	<ul style="list-style-type: none"> ▪ You pay \$0 for 24 one-way trips by van to covered medical appointments each year. ▪ Rides must be scheduled through the plan. 	Referral and prior authorization are required.
Medicare Part B Drugs	<ul style="list-style-type: none"> ▪ You pay 20% of the cost. 	Authorization required.

Prescription Drugs (Part D)

Part D Deductible: \$445 After the deductible, cost sharing is:	Retail or Mail order 30-day supply	Retail or Mail order 90-day supply	Long Term Care 31-day supply
Tier 1: Preferred Generic (Deductible does not apply)	You pay \$0	You pay \$0	You pay \$0
Tier 2: Generic	You pay 25%	You pay 25%	You pay 25%
Tier 3: Preferred Brand	You pay 25%	You pay 25%	You pay 25%
Tier 4: Non-Preferred	You pay 25%	You pay 25%	You pay 25%
Tier 5: Specialty Tier	You pay 25%	Not available	You pay 25%
Tier 6: Select Care (Deductible does not apply)	You pay \$0	You pay \$0	You pay \$0

- **You pay these amounts until your total yearly drug costs reach \$4,130.**
- **Coverage Gap Stage:** Once your total Part D drug costs have reached \$4,130, then you pay 25% of the cost for your drugs and a portion of the dispensing fee
- **Catastrophic Coverage Stage:** Once your yearly out-of-pocket drug costs reach \$6,550, you pay the greater of \$3.70 for generic or a preferred multi-source drug and \$9.20 for all other drugs, or 5%

Bonus Benefits

Premiums and Benefits	Coverage Details	What you should know
Acupuncture	You pay \$10 per treatment for up to 12 routine treatments per year.	Referral and prior authorization are required.
Health/Wellness	You pay \$0 for fitness center membership at multiple centers.	Home Fitness Kits and Stay Fit Kits also available.
In-home Safety Assessment	You pay \$0 for 1 in-home safety assessment per year.	Referral and prior authorization are required.
Home Meal Delivery	Available for up to: ▪ 5 days after a hospital stay ▪ 14 days for quarantined members	Up to 3 meals per day provided.
Over-the-Counter Drugs (OTC)	▪ \$100 allowance every quarter	Select a variety of items from our OTC catalog.



What you should know

Cost-Sharing may change depending on the pharmacy you choose and phase of the Part D benefit. For more information, please call us or access our Evidence of Coverage (EOC) online. Visit www.brandmanhealthplan.com to find:

- The provider & pharmacy directories
- The Formulary (list of covered drugs)
- The EOC - a complete list of benefits



**Brandman
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www.brandmanhealthplan.com

Member Services:

1-888-697-5662 / TTY 711

Hours:

October 1 – March 31: Seven days a week, from 8:00 a.m. to 8:00 p.m.

April 1 – September 30: Monday through Friday, from 8:00 a.m. to 8:00 p.m.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, or view it online at www.medicare.gov. This information is not a complete description of benefits. Call 1-888-697-5662/TTY 711 for more information. Out-of-network/non-contracted providers are under no obligation to treat Brandman Health Plan 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.

Brandman Health Plan Aspire-D is a HMO SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO SNP) depends on contract renewal. Brandman Health Plan (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-697-5662 (TTY: 711).





Thank you for considering Brandman Health Plan. Choosing the right plan with the right benefits is an important decision that requires careful thought and contemplation.

As we mature, our needs for health and wellness change. Brandman Health Plan is here to help. We provide benefits and services to Medicare-eligible individuals who have any one of the following chronic conditions:

- Diabetes
- Chronic Heart Failure
- Cardiovascular Disorders (high blood pressure, a history of stroke or coronary heart disease)
- Dementia

The Brandman Health Plan team is committed to serving you. We are passionate about making sure you receive the care and services that you deserve.

We encourage you to review the Summary of Benefits as it provides detailed information about the plans we offer. If you would like additional information or have any questions about completing the enrollment form or choosing a doctor, give us a call.

We look forward to serving you in 2021.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Martinez, Ph.D.", is placed over a horizontal line.

Stephen Martinez, Ph.D.
Chief Executive Officer



Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Agents use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Agent.**

Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

By signing this form, you agree to meet with a Licensed Agent to discuss only Medicare Advantage Plans in your area. The Licensed Agent **does not** work directly for Medicare or the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential. Brandman Health Plan is a HMO SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO SNP) depends on contract renewal.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:

Signature Date:

If you are the authorized representative, please sign above and print clearly and legibly below:

Authorized Representative's Name:

Your Relationship to the Beneficiary:

To be completed by the Licensed Agent (print clearly and legibly):

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Licensed Agent Signature:	



Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this 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.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- I recently was released from incarceration. I was released on (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- 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 (insert date) _____.
- 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 am moving into, 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 (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Brandman Health Plan at 1-888-697-5662 (TTY users should call 711) to see if you are eligible to enroll. We are open October 1 – March 31: Seven days a week, from 8:00 a.m. to 8:00 p.m. or April 1 – September 30: Monday through Friday, from 8:00 a.m. to 8:00 p.m.

Brandman Health Plan is a HMO SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO SNP) depends on contract renewal.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-697-5662 (TTY: 711).



Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-697-5662.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.brandmanhealthplan.com or call 1-888-697-5662 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- 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.

Understanding Important Rules

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

Brandman Health Plan is a HMO SNP with a Medicare contract. Enrollment in Brandman Health Plan (HMO SNP) depends on contract renewal.



Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have 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 in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (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:
Brandman Health Plan Aspire-D (HMO C-SNP)
P.O. Box 17960
Encino, CA 91416

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

How do I get help with this form?

Call Brandman Health Plan Aspire-D (HMO C-SNP) at 1-888-697-5662. TTY users can call 711.

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

En español: Llame a Brandman Health Plan Aspire-D (HMO C-SNP) al 1-888-697-5662/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1 – All fields on this page are required (unless marked optional)**Select the plan you want to join:**Brandman Health Plan Aspire-D (HMO C-SNP) 004 – \$31.50 per month

FIRST name:

LAST name:

Middle Initial:

Birth date:
(MM/DD/YYYY)Sex:
Male
FemalePhone number:
()

Permanent Residence street address (Don't enter a PO Box):

City:

County:

State:

ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Medicare/Medi-Cal information:**Medicare Number:**

- - - - -

Medi-Cal Number:

- - - - -

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Brandman Health Plan

Aspire-D (HMO C-SNP)? Yes No Name of other coverage: _____

Member number for this coverage: _____ Group number for this coverage: _____

Please list your current medications:

Have you been diagnosed with one or more of the following conditions?

 Dementia Alzheimer's Any cognitive memory issues

Do you use any assistive devices?

<input type="checkbox"/> None	<input type="checkbox"/> Shower chair	<input type="checkbox"/> Raised toilet seat
<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker
<input type="checkbox"/> Other: _____		

Name of your current DME company: _____ N/A

Please list any other immediate health concerns you may have:

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Brandman Health Plan Aspire-D (HMO C-SNP)
- By joining this Medicare Advantage Plan, I acknowledge that Brandman Health Plan Aspire-D (HMO C-SNP) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Brandman Health Plan Aspire-D (HMO C-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Brandman Health Plan Aspire-D (HMO C-SNP).

Benefits and services provided by Brandman Health Plan Aspire-D (HMO C-SNP) and contained in my Brandman Health Plan Aspire-D (HMO C-SNP) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Brandman Health Plan Aspire-D (HMO C-SNP) will pay for benefits or services that are not covered.

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature:

Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields in this next section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

Braille Large print Audio CD

What is your preferred language:

English Spanish Other _____

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Do you work? Yes No

Does your spouse work? Yes No

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

I want to get the following materials via email. Select one or more.

Information about plan benefits Provider/Pharmacy Directories All plan communications

E-mail address:

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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 - 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're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields in this next section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

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