

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 \$25 per month towards the cost of their monthly Medicare Rx or Medicare Advantage prescription drug premiums.

Qualified applicants also can receive up to \$1,200 per year towards their coverage gap or “doughnut hole” costs. If your drug costs total more than \$2,830 a year during 2010, SPDAP will pay a subsidy of up to \$1,200 to your Medicare Rx prescription drug plan or Medicare Advantage Plan to reduce your coverage gap or “doughnut hole” costs. **Not all plans will provide this subsidy.** To take advantage of the “doughnut hole” subsidy, you must be enrolled in one of the Medicare Rx prescription drug plans or Medicare Advantage Plans that has agreed to offer the “doughnut hole” subsidy.

If you have not done so already, you **must** enroll in a Medicare Rx prescription drug plan or a Medicare Advantage Plan to receive a premium subsidy of up to \$25 per month and a “doughnut hole” subsidy of up to \$1,200 per year. 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 \$25 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 ENCLOSEING 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

SPDAP Participating Prescription Drug Plans

Plan Name	Company Name	Monthly Premium with SPDAP	Maryland SPDAP "Doughnut Hole" Subsidy Offered & Member Cost Sharing during subsidy
Stand Alone Prescription Drug Plans with SPDAP \$1,200 Coverage Gap AND the \$25 Monthly Premium Subsidy			
AARP MedicareRx Preferred (S5820-004)	UnitedHealthcare	\$14.60	Yes, same copays as drug plan
AdvantRx Premier (S5670-028)	Coventry AdvantRx	\$23.60	Yes, 25% coinsurance
AdvantRx Premier Plus (S5670-030)	Coventry AdvantRx	\$38.80	Yes, 25% coinsurance
AdvantRx Value (S5670-027)	Coventry AdvantRx	\$16.40	Yes, 25% coinsurance
Blue Rx Enhanced (S5766-003)	Medi-CareFirst BlueCross BlueShield	\$95.20	Yes, same copays as drug plan
Blue Rx Standard (S5766-002)	Medi-CareFirst BlueCross BlueShield	\$49.40	Yes, same copays as drug plan
Bravo Rx (S5998-037)	Bravo Health Insurance Company	\$9.30	Yes, same copays as drug plan
Community CCRx Basic (S5803-074)	Universal American	\$3.20	Yes, 25% coinsurance
Community CCRx Choice (S5803-142)	Universal American	\$13.90	Yes, 25% coinsurance
Community CCRx Gold (S5803-222)	Universal American	\$56.10	Yes, 25% coinsurance
First Health Part D Premier (S5768-008)	First Health Part D	\$5.30	Yes, 25% coinsurance
First Health Part D Secure (S5768-087)	First Health Part D	\$0.00	Yes, 25% coinsurance
PrescribaRx Bronze (S5597-239)	Pennsylvania Life Insurance Co.	\$1.40	Yes, 25% coinsurance
PrescribaRx Gold (S5597-037)	Pennsylvania Life Insurance Co.	\$14.80	Yes, 25% coinsurance
WellCare Classic (S5967-142)	WellCare	\$5.50	Yes, same copays as drug plan
WellCare Signature (S5967-039)	WellCare	\$15.30	Yes, same copays as drug plan
Stand Alone Prescription Drug Plans with ONLY the SPDAP \$25 Monthly Premium Subsidy			
AARP MedicareRx Enhanced	UnitedHealthcare	\$54.00	No
AARP MedicareRx Saver	UnitedHealthcare	\$5.00	No
Advantage Freedom Plan	Rx America	\$16.00	No
Advantage Star Plan	Rx America	\$10.00	No
Aetna Medicare Rx Essentials	Aetna Medicare	\$6.80	No
Aetna Medicare Rx Plus	Aetna Medicare	\$8.60	No
Aetna Medicare Rx Premier	Aetna Medicare	\$71.70	No
CIGNA Medicare Rx Plan One	CIGNA Medicare Rx	\$6.60	No
CIGNA Medicare Rx Plan Two	CIGNA Medicare Rx	\$12.30	No
CIGNA Medicare Rx Plan Three	CIGNA Medicare Rx	\$41.70	No
CVS Caremark Complete	SilverScript Insurance Company	\$40.60	No
CVS Caremark Plus	SilverScript Insurance Company	\$26.00	No
EnvisionRxPlus Gold	EnvisionRx Plus	\$19.10	No
EnvisionRxPlus Silver	EnvisionRx Plus	\$11.40	No
Health Net Orange Option 1	Health Net	\$10.60	No
Health Net Value Orange Option 2	Health Net	\$14.00	No
HealthSpring Prescription Drug Plan – Reg 5	HealthSpring	\$6.80	No
Humana Complete	Humana Insurance Company	\$74.90	No
Humana Enhanced	Humana Insurance Company	\$16.90	No
Humana Value	Humana Insurance Company	\$5.70	No
Access	Medco Prescription Drug Plan	\$45.70	No
Choice	Medco Prescription Drug Plan	\$16.60	No
Medco Medicare Prescription Drug Plan – Value	Medco Prescription Drug Plan	\$7.90	No
MedicareRx Rewards Plus	Unicare	\$12.20	No
MedicareRx Rewards Standard	Unicare	\$8.40	No
SilverScript Value	SilverScript Insurance Company	\$9.70	No
Sterling Rx	Sterling Life Insurance Company	\$29.50	No
UA Medicare Prescription Drug Coverage	United American Insurance Co.	\$21.50	No
UA Medicare Prescription Drug Covg-Silver Plan	United American Insurance Co.	\$5.80	No

SPDAP Participating Prescription Drug Plans

Plan Name	Company Name	Monthly Premium with SPDAP	Maryland SPDAP "Doughnut Hole" Subsidy Offered & Member Cost Sharing during subsidy
Medicare Advantage Plans with SPDAP \$1,200 Coverage Gap AND the \$25 Monthly Premium Subsidy			
Bravo Achieve (HMO) (H2108-030)	Bravo Health	\$0.00	Yes, same copays as drug plan
Bravo Choice (HMO) (H2108-031)	Bravo Health	\$22.70	Yes, same copays as drug plan
Bravo Classic (HMO) (H2108-022)	Bravo Health	\$0.00	Yes, same copays as drug plan
Bravo Freedom (PPO) (H9184-002)	Bravo Health	\$54.50	Yes, same copays as drug plan
Bravo Liberty II Rx (PFFS) (H6421-012)	Bravo Health	\$90.00	Yes, same copays as drug plan
Bravo Premier Plus (HMO-POS) (H2108-026)	Bravo Health	\$68.80	Yes, same copays as drug plan
Bravo Traditions (HMO) (H2108-002)	Bravo Health	\$8.70	Yes, same copays as drug plan
Care Improvement Plus Gold Rx Plan (HMO) (H5665-002)	Care Improvement Plus	\$49.00	Yes, same copays as drug plan
Today's Options Premier powered by CCRx (PFFS)	Universal American		
Plan Number (H3333-113)		\$83.00	Yes, 25% coinsurance
Plan Number (H3333-121)		\$104.00	Yes, 25% coinsurance
Plan Number (H3333-129)		\$120.00	Yes, 25% coinsurance
Plan Number (H3333-137)		\$135.00	Yes, 25% coinsurance
Plan Number (H3333-145)		\$150.00	Yes, 25% coinsurance
Today's Options Value powered by CCRx (PFFS)	Universal American		
Plan Number (H3333-115)		\$14.20	Yes, 25% coinsurance
Plan Number (H3333-123)		\$55.20	Yes, 25% coinsurance
Plan Number (H3333-131)		\$60.10	Yes, 25% coinsurance
Plan Number (H3333-139)		\$75.10	Yes, 25% coinsurance
Plan Number (H3333-147)		\$90.10	Yes, 25% coinsurance
Medicare Advantage Prescription Drug Plans with ONLY the SPDAP \$25 Monthly Premium Subsidy			
Aetna Medicare Premier Plan (HMO)	Aetna Medicare	\$101.00	No
Aetna Medicare Premier Plan (PPO)	Aetna Medicare	\$174.00	No
Aetna Medicare Standard Plan (HMO)	Aetna Medicare	\$16.40	No
Aetna Medicare Standard Plan (PPO)	Aetna Medicare	\$122.20	No
Any, Any, Any Gold (PFFS)	Universal Health Care Insurance Co.	\$46.90	No
Any, Any, Any Platinum (PFFS)	Universal Health Care Insurance Co.	\$74.20	No
Evercare Plan IP	Evercare by UnitedHealthCare	\$8.70	No
Kaiser Permanente Medicare Plus High w/D AB (Cost)	Kaiser Permanente Medicare Plus	\$71.00	No
Kaiser Permanente Medicare Plus Std w/D AB (Cost)	Kaiser Permanente Medicare Plus	\$0.00	No
Security Choice Plus (PFFS)	Unicare Life & Health Company	\$33.90	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
100 Great Meadow Road
Suite 705
Wethersfield, CT 06109

SECTION I

1. PERSONAL INFORMATION (Please Print)

Name (as it appears on Medicare Card)				
	Last	First	MI	
Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: ____/____/____	
Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single

Spouse Name				
	Last	First	MI	
Date of Birth: ____/____/____				

Home Address: _____				
City: _____	State: _____	Zip Code _____		
Mailing Address (if different from home address) _____				
City: _____	State: _____	Zip Code _____		
How long have you been a resident of the state of Maryland? _____				

Home Phone Number (_____) _____
Social Security Number _____

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. Your Medicare Number should include nine numbers and at least one letter.

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	\$ 32,490	<p><i>Household Income</i> 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 is total income before deductions.</p> <p>You may use the worksheet on the following page to help you calculate your total household income for the current year.</p>
2 People	\$ 43,710	
3 People	\$ 54,930	
4 People	\$ 66,150	
5 People	\$ 77,370	
6 People	\$ 88,590	
7 People	\$ 99,810	
8 People	\$ 111,030	

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)) - <i>do not include rollovers</i>	\$	\$	\$	\$
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 home) worth more than \$12,510? Include the things you own by yourself or with someone else. **Do not include your home, 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 home) worth more than \$25,010? Include the things you own by yourself, with your spouse or with someone else. **Do not include your home, vehicles, burial plots or personal possessions.**

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)	<input type="checkbox"/> NONE	\$
Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	<input type="checkbox"/> NONE	\$
Any other cash at home or anywhere else	<input type="checkbox"/> NONE	\$

3. Do you own life insurance policies with a total face value of \$1,500 or more? If you are married and live with your spouse, does your spouse own life insurance policies with a total face value of \$1,500 or more? If you answered **NO** for both you and your spouse, go to question 4.

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

If the answer for either you or your spouse is **YES**, how much money would you get if you turned in your insurance policies for cash right now? Enter the amount. If you answered **YES** for both you and your spouse, enter the combined amount. (This is not the face value of your policies. You may need to call your insurance company to help answer this question.)

Enter the amount \$ _____

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

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

5. 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

6. 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	<input type="checkbox"/> NONE	\$
Railroad Retirement	<input type="checkbox"/> NONE	\$
Veterans	<input type="checkbox"/> NONE	\$
Other pensions or annuities (Do not include money you receive from any item you included in question 4.)	<input type="checkbox"/> NONE	\$
Other income not listed above, including alimony, net rental income, workers' compensation (Specify): _____	<input type="checkbox"/> NONE	\$

7. Have any of the amounts you included in question 6 decreased during the last two years?
 Yes No
8. Does anyone provide or help you or your spouse (if living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, or help with medical treatment and drugs.)
 Yes No

If you put an X in the **YES** box, enter the monthly amount, or if the amount changes from month to month, enter the average monthly amount for the past year. \$ _____

9. 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

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

If you answered "Yes" to question 9 for either you or your spouse, you must answer questions 11 through 14. If not, skip to question 15.

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

YOU: NONE \$ _____

SPOUSE (if living together): NONE \$ _____

12. 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.

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

Yes No

14. 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

If you are younger than age 65, you must answer the question 14 below. Otherwise, sign the application on page 12 and return it to us.

15. 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

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.