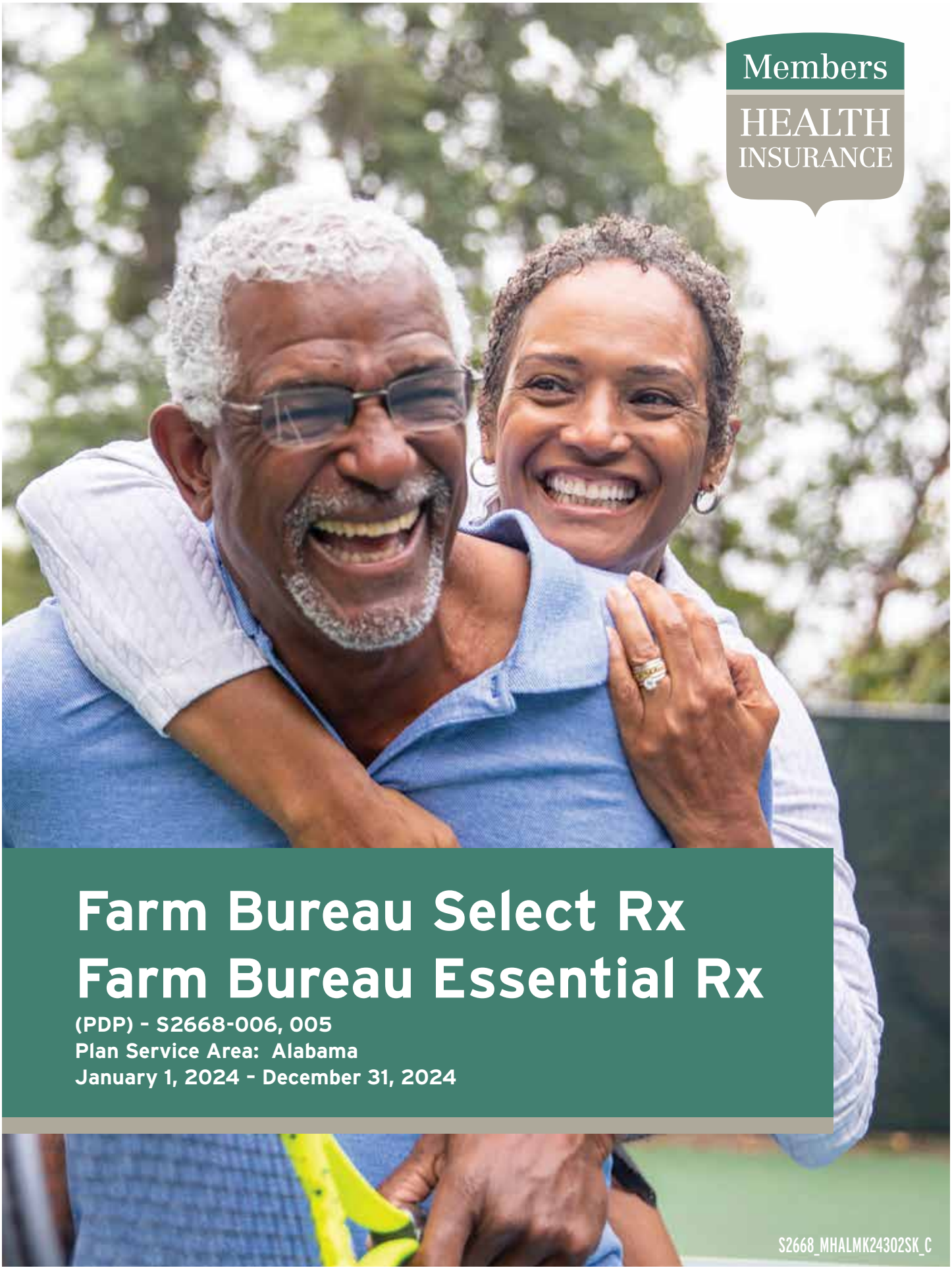

Farm Bureau Select Rx
Farm Bureau Essential Rx

(PDP) - S2668-006, 005
Plan Service Area: Alabama
January 1, 2024 - December 31, 2024

S2668_MHALMK24302SK_C

Table of contents

2024 Summary of Benefits
Members Health Insurance Company

This booklet gives you a summary of what **Farm Bureau Select Rx** (PDP) and **Farm Bureau Essential Rx** (PDP) covers and what you pay. It doesn't list every service that we cover or every limitation or exclusion. To get a complete list of services we cover, you can view our *Evidence of Coverage* online at **mhinsurance.com/part-d** or call Member Services for more information or to request an *Evidence of Coverage*.

Who can join?
To join Members Health Insurance Company, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in Alabama.

Enrollment information:
1-844-368-8739 (TTY/TDD: 711)
8 a.m. through 8 p.m. local time, seven days a week, October 1 through March 31.
8 a.m. through 8 p.m. local time, Monday through Friday, April 1 through September 30.

Member Services:
1-855-540-4744 (TTY/TDD: 711)
8 a.m. through 8 p.m. local time, seven days a week, October 1 through March 31.
8 a.m. through 8 p.m. local time, Monday through Friday, April 1 through September 30.

Visit us online
www.mhinsurance/part-d

Medicare:
1-800-MEDICARE (1-800-633-4227)
(TTY/TDD: 1-877-486-2048)
24 hours a day, 7 days a week

Website: medicare.gov

Social Security Administration:
1-800-772-1213
(TTY/TDD: 1-800-325-0778)
7 a.m. to 7 p.m., Monday through Friday

Members Health Insurance Company is a Prescription Drug Plan (PDP) with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal. S2668_MHALMK24303SB_M

Phases of Coverage

	Farm Bureau Essential Rx Begins	Farm Bureau Select Rx Begins		
	$545	$0	$5,030	$8,000
	Deductible Phase	**Initial Coverage Phase**	**Coverage Gap Phase (Donut Hole)**	**Catastrophic Coverage Phase**
	If you select the Farm Bureau Essential Rx plan with a deductible, you will pay all of your drug costs until you spend $545. If you select the Farm Bureau Select Rx plan you do not have a deductible.	You pay copays or coinsurance and the plan pays the difference until the total cost of drugs paid by both you and the plan reaches $5,030.	You pay 25% coinsurance for generic drugs and 25% coinsurance for brand drugs during this phase. You move into the Catastrophic Phase once you and others on your behalf have spent $8,000 on your drug costs.	Once you and others on your behalf have spent $8,000 in drug costs, the plan pays the full cost of your covered Part D drugs and you pay nothing.

You may be able to get Extra Help to pay for your prescription drug premiums, deductibles and costs. To see if you qualify for Extra Help, call the Social Security office at 1-800-772-1213, 7 a.m. to 7 p.m., Monday-Friday. TTY users should call 1-800-325-0778.

Are you a diabetic?

You won't pay more than $35 for a one-month supply of insulin, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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Farm Bureau Select Rx Plan

Medicare Part D Prescription Drug Plan:	Farm Bureau Select Rx Plan
Monthly Premium If you have Part B, you must continue to pay your Part B premiums.	**$76.70**
Annual Deductible	**$0**

Are you a diabetic?

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Initial Coverage Stage

During this stage, the Plan pays its share of the cost of your drugs and you pay your share of the cost. **You stay in this stage until your total drug costs for the year total $5,030.** Total drugs costs are your payments plus the Plan's payments.

Preferred Pharmacy

The Preferred Cost-Sharing Pharmacies for the Farm Bureau Select Rx plan are Kroger and Walmart.

Copay/ Coinsurance	The Preferred Cost-Sharing Pharmacies for the Farm Bureau Select Rx Plan are Kroger and Walmart.		Mail Order		Network Pharmacy (Standard Cost-Sharing Pharmacy)	
Tier Level	**30 - Day Supply**	**100 - Day Supply**	**30 - Day Supply**	**100 - Day Supply**	**30 - Day Supply**	**100 - Day Supply**
Tier 1 – Preferred Generic	$1	$3	$0	$0	$15	$45
Tier 2 – Generic	$9	$27	$0	$0	$20	$60
Tier 3 – Preferred Brand	$42	$126	$42	$126	$47	$141
Tier 4 – Non-Preferred Brand	45% of drug cost	45% of drug cost	33%	33%	50% of drug cost	50% of drug cost
Tier 5 – Specialty*	33% of drug cost	Not covered	33%	Not covered	33% of drug cost	Not covered

*Tier 5 drugs outside of 30 day supply are not covered.

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Farm Bureau Essential Rx Plan

Medicare Part D Prescription Drug Plan:	Farm Bureau Essential Rx Plan
Monthly Premium If you have Part B, you must continue to pay your Part B premiums.	**$37.10**
Annual Deductible	**$545**

Are you a diabetic?

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Beneficiaries who qualify for Medicare's low-income subsidy already receive help on their premium and out-of-pocket costs. If you already receive a low-income subsidy, the $35 copayment does not apply.

Deductible Stage

The Deductible Stage is the first stage of your drug coverage. This stage begins when you fill your first prescription of the year. During this stage, you pay the full cost of your drugs.

Once you have paid $545 for your drugs, you leave the Deductible Stage and move to the Initial Coverage Stage.

Initial Coverage Stage

During this stage, the Plan pays its share of the cost of your drugs and you pay your share of the cost. **You stay in this stage until your total drug costs for the year total $5,030.** Total drugs costs are your payments plus the Plan's payments.

Copay/Coinsurance	Network Pharmacy	
Tier Level	**30 - Day Supply**	**100 - Day Supply**
Tier 1 – Preferred Generic	$5	$15
Tier 2 – Generic	$12	$36
Tier 3 – Preferred Brand	$47	$141
Tier 4 – Non-Preferred Brand	50% of drug cost	50% of drug cost
Tier 5 – Specialty	25% of drug cost	Not covered

Important things to know

Additional Copay Information

- If you use a network **Long Term Care Pharmacy**, the Standard Cost-Sharing Pharmacy copayments and coinsurance apply to a 31-day supply.
- If you use a network **Home Infusion Pharmacy**, the Standard Cost-Sharing Pharmacy copayments and coinsurance apply to a 30-day supply.

Coverage Gap Stage

During this stage, the Medicare Coverage Gap Discount Program provides **70% manufacturer discounts on brand name drugs.** This discount is automatically applied when your pharmacy charges you for your prescription. You also receive some coverage for generic drugs during the Coverage Gap Stage.

For brand name drugs, you pay 25% (plus a portion of the dispensing fee) and the plan pays the remaining 5%.

For generic drugs, you pay 25% of the price and the Plan pays 75%.

You stay in this stage until your year-to-date out-of-pocket costs reach $8,000.

Your out-of-pocket costs include amounts you have paid for your prescription drugs plus manufacturer discount amounts for your brand drugs. The out-of-pocket amount does not include what the Plan has paid.

Our plan covers most Part D vaccines at no cost to you even if you haven't paid your deductible.

Catastrophic Stage

Once your out-of-pocket costs reach $8,000, you enter the Catastrophic Stage. During this stage, the Plan will pay the full cost of your covered Part D drugs and you pay nothing.

Important pharmacy information

Out-of-Network Pharmacy Coverage

In most cases, your prescription drugs are covered only if they are filled at a network pharmacy. However, there are some circumstances when the Plan will cover prescriptions filled at an out-of-network pharmacy, such as:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a drug timely because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network pharmacy.

You will likely pay more than your normal cost-share if you get your drugs at an out-of-network pharmacy. You may be required to pay the difference between what you paid for the drug and the cost of the drug at a network pharmacy.

In addition, you will likely have to submit documentation to receive reimbursement from the Plan.

Network Pharmacies

A network pharmacy is a pharmacy that has contracted with the Plan to provide your covered prescription drugs. There are certain network pharmacies that have agreed to special pricing, known as Preferred Cost-Sharing Pharmacies. Your copay and coinsurance may be lower when using a Preferred pharmacy. Preferred Cost-Sharing Pharmacies are only available with membership in a Farm Bureau Select Rx plan.

To locate a network pharmacy, you can look in your Pharmacy Directory, visit our website at **mhinsurance.com/part-d** or call Member Services.

Which drugs are covered?

You should review the **list of covered drugs (Formulary)** to make sure your prescription drugs are covered and to determine if there are any restrictions, such as quantity limits or prior authorization. The Formulary will also show you the drug's Tier so you can determine what the drug will cost you in the Initial Coverage Stage. You can view the **Formulary** by visiting our website at **mhinsurance.com/part-d** or by calling Member Services to have a copy sent to you.

When to enroll

It is important for you to know when you can enroll, disenroll, or make changes to your prescription drug plan. If you do not enroll when you are first eligible, you may have to pay a late enrollment penalty.

Who can enroll?

You can enroll in a Part D plan if you meet the basic eligibility requirements:

- You must be entitled to Medicare Part A and/or be enrolled in Part B; and
- You must live within the service area, which is the state of Tennessee.

Medicare Initial Enrollment Period (IEP)

You can enroll in a Part D plan when you are first eligible for Medicare. The Initial Enrollment Period is a 7-month period that includes the three months before you turn age 65, the month you turn age 65, and the 3 months after you turn age 65.

Medicare Annual Enrollment Period (AEP)

You can enroll in, cancel, or change your prescription drug plan during the AEP, which is each year from October 15 to December 7.

Medicare Advantage Open Enrollment Period (OEP)

If you are currently enrolled in a Medicare Advantage plan you can switch to another Medicare Advantage plan with or without drug coverage, or choose to enroll in Original Medicare. These changes may allow you to select a Prescription Drug plan. This period is January 1 to March 31 each year.

Special Enrollment Period (SEP)

You can enroll in a prescription drug plan if you qualify for an SEP. You may qualify for an SEP if you have certain life events or if you are eligible for Extra Help with your prescription costs.

More information about Medicare:

If you want to know more about Medicare enrollment periods or the coverage and costs of Original Medicare, look in your current Medicare & You handbook.

You can view the Medicare & You handbook online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

Information on Extra Help

Extra Help
If you get extra help from Medicare to pay for your Medicare prescription drug plan costs, your monthly plan premium will be at no cost for Farm Bureau Essential Rx. This does not include any Medicare Part B premiums you may have to pay. Members of Farm Bureau Select Rx do not qualify for Extra Help.

This table shows you what your monthly plan premium will be if you get extra help. This does not include any Medicare Part B premium you may have to pay.

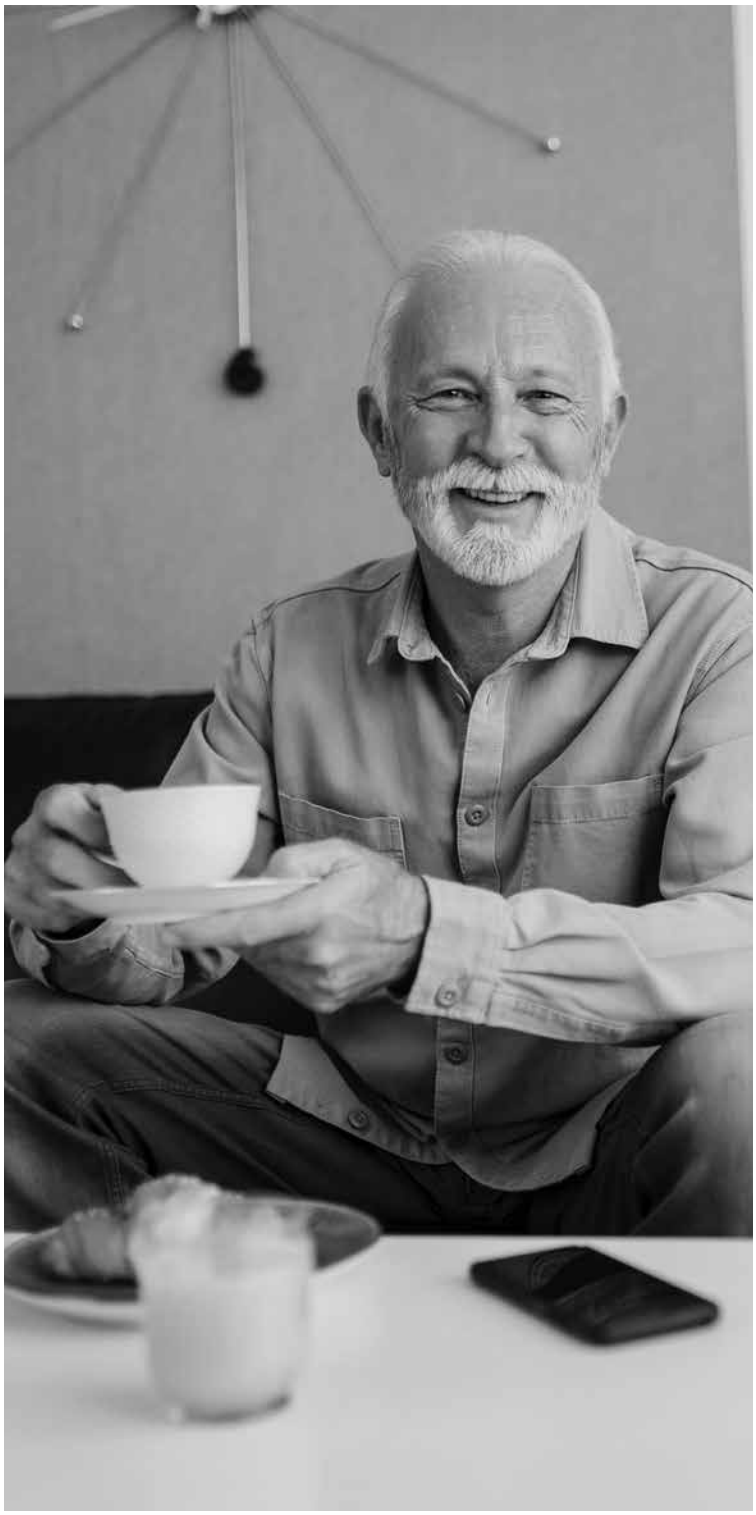
For additional plan details, see the Evidence of Coverage (EOC), which is located on our website at **mhinsurance.com/part-d** or call Member Services to request a copy.

To find out if you qualify for Extra Help Call:

Social Security Administration
1-800-772-1213
TTY/TDD users should call 1-800-325-0778
7 a.m. to 7 p.m., Monday – Friday

Medicare
1-800-MEDICARE (1-800-633-4227)
TTY/TDD users should call 1-877-486-2048
24 hours a day, 7 days a week www.medicare.gov

Your State Medicaid Office - TennCare
1-800-342-3145
TTY/TDD users should call 1-877-779-3103



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 Member Services at 1-855-540-4744.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **mhinsurance.com/part-d** or call 1-855-540-4744, TTY/TDD 711, to view a copy of the EOC.

- ☐ 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

- ☐ In addition to your monthly plan premium, 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, 2025.

- ☐ 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).

- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

OMB No. 0938-1378
Expires: 7/31/2024

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

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 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:

Members Health Insurance Company
P. O. Box 240
Columbia, TN 38402

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

How do I get help with this form?

Call Members Health Insurance Company at 1-866-643-6924. 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 Members Health Insurance Company al 1-866-643-6924/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.

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

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Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:
☐ Farm Bureau **Select Rx**: - **$76.70** per month ☐ Farm Bureau **Essential Rx**: - **$37.10** per month

FIRST name: LAST name: (Optional: Middle Initial)

Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐Female	Phone number: ( )

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

City:	(Required) County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare number: __ __ __ __ - __ __ __ - __ __ __ __

Hospital (Part A) Effective Date: _____

Medical (Part B) Effective Date: _____

Information is located on your red, white and blue Medicare card.

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Farm Bureau Select Rx/Essential Rx? ☐ Yes ☐No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

Do you work? ☐ Yes ☐ No

If yes, do you have other health care coverage from your employer? ☐ Yes ☐ No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

Does your spouse work? ☐ Yes ☐ No

If yes, do you have other health care coverage from your employer? ☐ Yes ☐ No

If yes, name of other coverage: _____

Member number for this coverage: _____

Group/Policy number for this coverage: _____

Effective date for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) or Medical (Part B) to stay in Members Health Insurance Company.
- By joining this Medicare Prescription Drug Plan, I acknowledge that Members Health Insurance Company 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.
- 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.
- I understand that when my Members Health Insurance Company coverage begins, I must get all of my prescription drug benefits from Members Health Insurance Company. Benefits and services provided by Members Health Insurance Company and contained in my Members Health Insurance Company "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Members Health Insurance Company will pay for benefits or services that are not covered.
- 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 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:
Broker Information	
Broker/Agent name:	Broker/Agent ID number:

Section 2 – All fields in this section are optional

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin

☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino/a, or Spanish origin

☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White

☐ **I choose not to answer.**

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Members Health Insurance Company at 1-844-368-8739 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. local time, 7 days a week October 1 - March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 - September 30 our hours are 8 a.m. to 8 p.m. Monday - Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY users can call 711.

Additional Contact Information

Email Address: _____

Alternate Phone Number: _____

Paying your plan premiums

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail, Electronic Funds Transfer (EFT), credit card 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.**

☐ Direct Bill ☐ Bank Withdrawal (EFT) ☐ Social Security or RRB

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. DON'T pay Members Health Insurance Company the Part D-IRMAA.

Office Use Only:

SEP Type: _____

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 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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Attestation of Eligibility for an Enrollment Period

PO Box 240
Columbia, TN 38402

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.

☐ 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 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.

If none of these statements applies to you or you're not sure, please contact Members Health Insurance Company at 1-844-368-8739 (TTY users should call 711) to see if you are eligible to enroll. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY user should call 711.

Notes

P.O. Box 240
Columbia, TN 38402

PART D PLANS

MEMBER PREMIUM BILLING/PAYMENT FACT SHEET

Premium Payment Options

Option 1 – Direct Member Pay via Check

- Members will receive invoices approximately ten (10) days in advance of the due date.
- Members can mail a check directly to the remittance address on the invoice and must include their payment coupon.
- Members can elect to pay the current month or prepay for subsequent months.
- Depending on when the member's payment is received, the payment may not be reflected until next month's invoice. Members can call Member Services or their bank to confirm a payment was received and processed.
- Members should allow up to five (5) **business** days for the payment to be received, processed, and posted to their account.

Option 2 – Direct Member Pay via Credit/Debit Card (one time)

- Members will receive invoices approximately ten (10) days in advance of the due date.
- Alabama Members can call Invoice Cloud at 1-844-798-0497 or pay online by visiting the website address http://www.invoicecloud.com/membershealthinsuranceco.
- Members will use their Subscriber ID, Last Name, and Zip Code to pull up their invoice that is due.
- When paying an active invoice, members can choose to pay the current month's premium or pay multiple months in advance.

Option 3 – Automatic Deduction of Premium from Checking Account

- Members **must** complete a Bank Withdrawal Pre- Authorization Form and mail the form to the FBHP Part D Billing Department, P.O. Box 240 Columbia, TN 38402 before

payments can be processed. Note that for checking accounts, a voided check **MUST BE** attached to the form. ***Federal law prohibits an employer from making Medicare premium payments for an active employee.***

- Due to the timing of the receipt of this form and processing, the bank withdrawal authorization may not be processed in time for the current month's premium and, as such, either a one-time credit card payment will be required, or the member will need to pay via check.
  - The request could take up to a month to auto-debit the member's account. The member may get an invoice and will need to pay until the bank processes the form to complete the process. The member can also reach out to the bank to confirm the status of their auto-debit.

- This form can be downloaded from the Members Health Insurance Company Medicare Part D website https://mhinsurance.com/part-d/premium-payment-terms-conditions .

- Members should retain a copy of their completed authorization form.

- If a member has elected to have the recurring payments from a checking account, **no invoice will be provided,** and their checking account statement shall serve as their receipt.

- Members cannot set up automatic deduction of premium from a checking account over the phone. The completion of a Bank Withdrawal Pre-Authorization Form is required.

Option 4 – Automatic Deduction of Premium through Credit/Debit Card

- Alabama Members **will** sign up for automatic recurring Auto Pay Credit/Debit Card monthly payments by visiting http://www.invoicecloud.com/membershealthinsuranceco to register their policy and set up Auto Pay.

- Members will use their Subscriber ID, Last Name, and Zip Code to pull up their invoice that is due.

- Members will select Register Policy at the bottom of the page and will be asked to include an email address and set up a password.

- Members will need to add a credit or debit card to their account and select the Auto Pay option to complete their Auto Pay set up.

- If a member has elected to have the recurring payments from a credit card, **no invoice will be provided,** and their credit card statement shall serve as their receipt.

Option 5 – Automatic Deduction of Premium from Social Security or Railroad Retirement Board Check

Members Health Insurance Company is a Prescription Drug Plan (PDP) with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.

- Members **may** request their Part D premiums be withheld from their Social Security check by calling Member Services at 855-540-4744 (TTY 711) to request the deduction be set up. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays.

If a member chooses to have the premium withheld from their Social Security or Railroad Retirement Board benefit check, you may receive an invoice for your first month or two of enrollment if the deduction does not start right away or does not start at all. If a member has elected to have their premiums deducted from their social security check, their monthly check remittance from SSA will serve as their receipt and **no invoice will be provided.**

Members who fail to pay the monthly premium may be disenrolled from Farm Bureau Health Plans.

If you have questions or want more information, call Members Health Insurance Company at 1-855-540-4744. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31 during which time our automated phone system may answer your call on Thanksgiving and Christmas day. April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY users should call 711.

Bank Withdrawal Pre-Authorization Form

Name of Account Holder _____
(Please print)

Name of Member _____**ID Number**_____
(If different than Account Holder)

Bank Name _____ **Bank Address** _____

City _____ **State**_____

Account Type: *(check one)* ☐ **Checking** ☐ **Savings**

Bank Draft Date: Your draft will occur on the 1st of the month. If the 1st of the month falls on a weekend or bank holiday, your draft will occur on the next banking day.

For Savings Accounts Only: *(For Checking Accounts, please attach a blank, voided check below)*
Bank Routing #: _____ Account #: _____

I hereby authorize the bank or financial organization named above to pay my plan premium through monthly check or electronic account debits drawn by and payable to Members Health Insurance Company (the Company). I understand and agree that, if any payment authorized hereby is denied, the Company will contact me to make arrangements for an alternate form of payment, and that, if I provide, verbally or in writing, corrected information for the account, this authorization includes full authority for the Company to charge the account using such corrected information.

X _____ Date _____
(Account holder, please sign as signature appears on signature card at bank)

Please tape (do not staple) a blank, voided check in the space that you would like your premium payment deducted from.

Please return this form to: P.O. Box 240, Columbia, TN 38402 or **Fax** to 1-800-784-1580

Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.

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ELECTION FORM FOR PREMIUM WITHHOLD FROM SOCIAL SECURITY
(SSA/RRB Withhold)

By completing this form, you are requesting to have your Members Health Insurance Company prescription drug benefit plan premium automatically deducted from your monthly Social Security (SSA) or Railroad Retirement Board (RRB) check. **To ensure the best opportunity for approval, the request may be submitted for a future effective date of up to 90 days from the date of receipt.** After your premium withhold form is processed, you will be notified of the effective date that your deduction is scheduled to begin. Until then, please continue to pay your plan premium. Generally, you must stay with the same premium payment option you choose for the rest of the year.

Name (Please Print) _____ Members Health Insurance Company ID# _____

Street Address _____ City, State, Zip Code _____

☐ **Yes, I would like to have my premium deducted from my monthly SSA or RRB benefit check.**

I receive monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board

Remember: Until you receive notification from Members Health Insurance Company that your deduction is scheduled to begin, please continue to pay your monthly plan premium.

*Signature _____ Date _____

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign this document. ***Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law.***

*If authorization form is for two members, both members must sign and provide their ID numbers for proper identification.

If you have any questions, please contact Members Health Insurance Company Customer Service at 1-855-540-4744. TTY users should call 711. From October 1 through March 31, our hours of operation are 8:00 a.m. until 8:00 p.m. local time, seven days a week during which our automated phone system may answer your call on Thanksgiving and Christmas Day. From April 1 through September 30, our hours of operation are 8:00 a.m. until 8:00 p.m. local time, Monday through Friday. Outside these hours, you may leave us a message and a representative will return your call the next business day.

Members Health Insurance Company is a Part D plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.

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Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Members Health Insurance Company complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction record, or military participation in the administration of the plan, including enrollment and benefit determinations.

Members Health Insurance Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of these services, contact Member Services at 1-855-540-4744 (TTY 711). Our hours of operation are Oct. 1 - March 31, 8 a.m.– 8 p.m. 7 days/week local time, and April 1 - Sept. 30, 8 a.m. – 8 p.m., Monday - Friday local time.

If you believe Members Health Insurance Company has failed to provide these services or has discriminated in another way based on race, color, national origin, age, disability, or sex, health status, marital status, arrest or conviction record, or military participation, you can file a complaint or grievance with us. You can mail your grievance to:

Members Health Insurance Company
ATTN: Grievances
P.O. Box 240
Columbia, TN 38402

If you need assistance filing a complaint or grievance, please call Member Services at the phone number listed above.

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby/jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019
1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

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 1-855-540-4744Someone 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 1-855-540-4744. 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 1-855-540-4744。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 1-855-540-4744。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 1-855-540-4744. 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 1-855-540-4744. 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 quí vị cần thông dịch viên xin gọi 1-855-540-4744 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-540-4744. 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 1-855-540-4744 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 1-855-540-4744. 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 **1-855-540-4744** 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 1-855-540-4744 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 1-855-540-4744. 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 1-855-540-4744. 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 1-855-540-4744. 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 1-855-540-4744. 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ございます。通訳をご用命になるには、1-855-540-4744 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。