10-step Guide to Self-enrollment Prescription Drug Plan (PDP) **STEP 1** Click on the link below (or copy and paste into your internet browser): https://myseniorinsurancequotes6.destinationrx.com/PC/2021/ **STEP 2** Enter your zip code and click on "View plans" My Senior Quotes.com J Contact us 📜 Cart Login 🗸 A non-government site sponsored by Financial Grade Senior Consultants Get covered Finding a Medicare plan that is right for you has never been so easy *ZIP code View plans

Enter your preferences

You will be able to enter your prescriptions and pharmacy to get a plan that is a best match for you. We'll estimate out-ofpocket spending to help you find a plan that saves you money.

Enter your preferences



Click on "Prescription Drug Plans"







✓ Contact us
Contact us
✓ Contact us

75 plans available in <u>92101</u> 🖻



Click on "Prescription drug"

$^{*}\ensuremath{\mathsf{If}}$ you get any extra help with prescriptions, select the applicable option

Click on "Continue"

| My Senior Quotes.com Insurance Quotes.com A non-government site sponsored by Financial Grade Senior Consultants | J Contact us ☐ Cart Login ∨ |
|--|---|
| | Get Started |
| Get Started | *ZIP code |
| ⊖ Health | 92101 San Diego, CA |
| Prescriptions | These optional questions help us estimate your potential costs |
| O Pharmacy | What coverage type are you interested in? (Optional) |
| Go to plans > | + Medical only Prescription drug Hedical and prescription drug I don't know |
| | Do you receive extra help paying for prescription drugs?(Optional) |
| | I receive help from Medicaid |
| | l get supplemental security income |
| | I belong to a Medicare Savings Program (MSP) |
| | I applied for and got extra help through social security |
| | No, I am not eligible for special assistance |
| | l don't know |
| | |
| | |
| | Previous Skip > Continue |

Use the search box to start entering your prescriptions <u>one by one</u> (ENSURE YOUR CLICK THE EXACT MEDICATION, taking into consideration dosage and type (i.e. capsule, tablet, etc.)

| | X | J Contact u |
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| A non-government site sponsored by Financial Grade Senior Consultants | | 📜 Cart Login |
| | | 00 |
| | Dr | |
| | Add your prescription | rs to see how each plan provides coverage. |
| Get Started | Search prescriptions | s Q |
| ⊖ Health | | |
| Prescriptions | Ambien CR Select your dosage and enter the amo | ount you use below. The most common dosage and |
| O Pharmacy | quantity is prefilled. | |
| Go to plans > | Select dose and form | Enter quantity and frequency |
| | Ambien CR TAB 6.25MG | 30 per month • |
| | Ambien CR TAB 12.5MG | |
| | | |
| | According to the FDA, this generic dr | ug has the same quality, strength, safety and active |
| | ingredient as the brand name drug. | |
| | Yes No | <u> </u> |
| | Cancel | Add |
| | Click on " <i>Add</i> " until you have | e added ALL prescriptions |
| | Your prescriptions | |
| | Your prescriptions Amaryl TAB 4MG | Edit 🗙 |

6

Select your pharmacy from the list and click on "Add pharmacy"

Click on "Continue

Click on the box under "Sort" to bring up the drop-down menu (4 options)

*We recommend sorting by "Total Estimated Annual Cost" (lowest cost annually)

Select your desired plan and click on "Add to cart"

YOU WILL BE REDIRECTED TO THE CARRIER'S SITE

| My Senior | | J Contact us |
|--|--|------------------------------------|
| A non-government site sponsored Pinancial Grade Senior Consulta | cont Ny Na | 📜 Cart Login 🗸 |
| | My cart | |
| Prescription D | rug Plan | |
| ♥aetna | SilverScript SmartRx (PDP) S5601-207 View details Change plan Remove plan | Monthly plan premium \$7.20 |
| | Enrollment information | × thiy plan premium \$7.20 |
| | You will now be redirected to the carrier's form to complete your enrollment in SilverScript SmartRx (PDP) S5601-207. Click "Continue" to be redirected. | |
| < Previous | Close | Continue to apply |
| | | J Contact us |

Click "Continue" to be redirected to the carrier's site for application completion and submission

Complete the application information and click "Continue"

| | | | 3 | 4 |
|--|--------------------------------|--------------------|------------------|---|
| Contact Info | B | enefit Info | Other Info | Review & Submit |
| Contact Inf | Shopping cart | | | |
| Use the form below to appl about mistakes. You'll be ab before you submit your con | ♥aetna | | | |
| Please Note: If you close thi sponsor's Online Enrollmen | Prescription \$7. Drug Plan | | | |
| Please contact the plan dire format (braille). | ectly if you need i | information in ano | ther language or | S5601-207 |
| Fields marked with an aster | Total monthly pl premiu | | | |
| | | | | \$7. |
| Personal Inform | nation | | | Enrollment Form |
| Please enter your personal | information in th | e spaces provided. | | <u>Formulario de inscripción</u> (Español) |
| Title | Mr. M | Irs. Ms. | | <u>Enrollment Plan Guide</u> <u>Guía del plan de inscripciór</u> |
| | | | | <u>(Español)</u> Summary of Benefits |
| | | | | Resumen de Beneficios |
| First Name* | | | | (Ecopol) |
| First Name* Middle Initial | | | | <u>(Espanoi)</u> Formulary |
| First Name* Middle Initial | | | J | <u>(Espanol)</u> Formulary Formulario (Español) Evidence of Coverage |
| First Name* Middle Initial Last Name* | | |] | (<u>Español)</u> Formulary Formulario (<u>Español)</u> Evidence of Coverage Evidencia de Cobertura (Español) |
| First Name* Middle Initial Last Name* Date of Birth* | | Y | | (<u>Espanoi)</u> Formulary Formulario (<u>Español)</u> Evidence of Coverage Evidencia de Cobertura (<u>Español)</u> Low Income Subsidy |
| First Name* Middle Initial Last Name* Date of Birth* Gender* | MM/DD/YYY | Y |] | (<u>Espanol)</u> Formulary Formulario (<u>Español)</u> Evidence of Coverage Evidencia de Cobertura (<u>Español)</u> Low Income Subsidy Information Subsidio de Bajos Ingresos |
| First Name* Middle Initial Last Name* Date of Birth* Gender* | MM/DD/YYY Male | Y Female | | (<u>Español)</u> Formulary Formulario (<u>Español)</u> Evidence of Coverage Evidencia de Cobertura (<u>Español)</u> Low Income Subsidy Information Subsidio de Bajos Ingresos (<u>Español)</u> Star Datigos |

Complete the Benefits information and click "Continue"

AETNA MEDICARE

DO NOT COMPLETE THIS SECTION DURING MEDICARE'S ANNUAL ENROLLMENT PERIOD (AEP October 15th thru December 7th)

Application will be declined if any option is selected

Eligibility

Typically, you may enroll in a Medicare Advantage or Prescription Drug 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 or Prescription Drug 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 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 recently returned to the United States after living permanently outside of the U.S. ②

□ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).

I am leaving employer or union coverage.

□ I have had Medicare prior to now, but am now turning 65. 🚱

- □ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage Plan.
- □ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan ②
- 🗆 I am new to Medicare. 🚱

- 1. Read disclosure statement and click "I have read and agreed to the [CARRIER NAME] Terms and Conditions"
- 2. Choose the applicable option for the person completing the online form
- 3. Click on "Submit"

I have read and agreed to the Aetna Medicare Terms and Conditions.

Please select the statement below that best describes your relationship to the person with Medicare listed on this enrollment form:*

I am the person listed on this enrollment form

I am legally authorized to represent the enrollee

I am a caregiver for the applicant

When you click Submit Enrollment, you will recieve a confirmation number. Additionaly information may be required if any information is incomplete or unverifable.

< Previous

Submit

CONGRATULATIONS!

YOUR APPLICATION HOW NOW BEEN SUBMITTED!

Prescription Drug Plan SilverScript SmartRx (PDP) S5601-207 Monthly plan premium \$7.20