SHICK Initial Counselor Training
Course 2 Introduction to Medicare Part C (Advantage), Medicare Part D, and Medigap

Online Pre-Training

Rev. 2/2020

SHICK Online Pre-Training

- Course 2 provides basic training in Medicare Prescription Drug Coverage including Part D, Part C Medicare Advantage plans, and Medicare Supplement Insurance (Medigap).
- You should thoroughly study the course including the notes. You will need to pass an exam after this course before continuing to Course 3 Introduction to Medicare Coordination, Protections, and More.

AD ASTRA

Medicare Prescription Drug Coverage

- Prescription drug coverage under Original Medicare Part A, Part B, or Part D depends on
  - Medical necessity
  - Health care setting
  - Medical indication (why you need it, like for cancer)
  - Any special drug coverage requirements
    - Such as immunosuppressive drugs following a transplant

AD ASTRA

Medicare Prescription Drug Coverage

Whether prescription drugs are covered under Medicare Part A, Part B, or Part D depends on several factors:

- Medical necessity
- The health care setting (for example, home, hospital (as inpatient or outpatient), or surgery center) where the health care is given
- The medical indication or reason why you need medication (for example, for cancer treatment)
- Any special coverage requirements, like those for immunosuppressive drugs that would be used following an organ transplant

This information applies if you have Original Medicare, fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

If you have a Medicare Advantage (MA) Plan (Part C) (like an HMO or a PPO) with prescription drug coverage, you get all of your Medicare-covered health care from the plan, including covered prescription drugs. Most MA Plans offer prescription drug coverage.

Part A Prescription Drug Coverage

- Part A generally pays for
  - All drugs during a covered inpatient stay received as part of treatment in a hospital or skilled nursing facility
  - Drugs used in hospice care for symptom control and pain relief only

Medicare Prescription Drug Coverage

AD ASTRA

You may get drugs as part of your treatment during a covered inpatient hospital or skilled nursing facility (SNF) stay. Medicare Part A payments made to hospitals and SNFs generally cover all drugs you get during an inpatient stay.

You may get drugs for symptom control or pain relief while receiving Part A-covered hospice care. You may be charged up to $5 for each outpatient prescription drug or other similar products for pain relief and symptom control.

Hospices must give virtually all care that terminally ill individuals need. Because hospice care is a Part A benefit, Part D doesn't pay for drugs covered under the Medicare Part A per diem payment to the hospice.

NOTE: If you don't have Part A coverage, Medicare Part B can pay hospitals and SNFs for certain categories of Part B covered drugs. If you do have Part A, Part B may pay if the Part A coverage for your stay has run out, or if your stay isn't covered by Part A.

Also, when receiving Part A covered SNF care, the SNF's bundled per diem payment excludes certain costly and intensive chemotherapy drugs. They're billed separately under Part B.

Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
  - Most injectable and infusible drugs given as part of a doctor's service
  - Drugs and biologicals
    - Used for the treatment of End-Stage Renal Disease
  - Drugs used at home with some types of Part B covered durable medical equipment
    - Such as nebulizers and infusion pumps
  - Some oral drugs with special coverage requirements like
    - Certain oral anti-cancer and antiemetic drugs
    - Immunosuppressive drugs, under certain circumstances

Medicare Prescription Drug Coverage

AD ASTRA

Medicare Part B gives limited prescription drug coverage. It doesn't cover most drugs you get at the pharmacy. Nearly all Part B covered drugs fall into the following categories:

- Most injectable and infusible drugs that aren't usually self-administered and that are given in a doctor's office (for example, an injectable drug used to treat anemia that's administered at the same time as chemotherapy). However, if an injection is usually self-administered (like Imitrex® for migraines) or isn't given as part of a doctor's service, it isn't covered by Part B.
- Drugs and biologicals used for the treatment of End-Stage Renal Disease (ESRD) are furnished by the ESRD facility responsible for the person's care. For example, any drug and biological used for anemia management is covered under Part B when furnished by an ESRD facility.
- Drugs administered through Part B covered durable medical equipment (DME) in your home (like a nebulizer or infusion pump). To get drugs covered by Medicare Part B, choose a pharmacy or supplier that's a participating DME provider. You may have to use a contract provider in certain areas and for certain DME products. For more information or to find contract providers in your area, visit the Medicare Supplier Directory at Medicare.gov/supplierDirectory.
- Three categories of oral drugs with special coverage requirements: certain oral anti-cancer, oral antiemetic (to treat nausea), and immunosuppressive drugs (under certain circumstances).

A limited number of other types of outpatient drugs. There may be regional differences in local Part B drug coverage policies in cases where there isn't a national coverage decision.

NOTE: For more details about covered drugs with special coverage requirements, visit the Medicare Claims Processing Manual Chapter 17—Drugs and Biologicals at CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf.

Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
  - Flu shot
  - Pneumococcal shot (to prevent pneumonia)
  - Hepatitis B shot
- Part B may cover certain vaccines after exposure to a disease or after an injury
  - Tetanus shot

Medicare Prescription Drug Coverage

AD ASTRA

Medicare Part B covers certain immunizations as part of Medicare-covered preventive services. If you meet the criteria, Part B covers:

- The flu shot.
- The pneumococcal shot (to prevent certain types of pneumonia).
- The Hepatitis B shot (for individuals at medium-to-high-risk for Hepatitis B). Some factors that put you at medium-to-high-risk for Hepatitis B are hemophilia, ESRD, diabetes, living with someone that has Hepatitis B, or if you’re a health care worker and have frequent contact with blood or body fluids.
- Other vaccines (like a tetanus shot) you get to treat an injury or if you’ve been exposed directly to a disease or condition.

Medicare drug plans (Part D) must cover all commercially available vaccines (like the shingles shot) when medically necessary to prevent illness.

Self-administered Drugs in Hospital Outpatient Settings

- Part B doesn't cover self-administered drugs in a hospital outpatient setting
  - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
  - If not admitted to hospital
  - May have to pay and submit for reimbursement

AD ASTRA

Medicare Prescription Drug Coverage

There may be a need for self-administered drugs (drugs you'd normally take on your own) in hospital outpatient settings, like the emergency department, observation units, surgery centers, or pain clinics. For example, you may need daily blood pressure medication while in the emergency room for a sprained ankle. Medicare Part A and Part B wouldn't cover the medication because it's not related to the outpatient services you're getting to treat your ankle. If you get self-administered drugs that aren't covered by Medicare Part A or Part B while in a hospital outpatient setting, the hospital may bill you for the drug.

However, if you're enrolled in a Medicare drug plan, these drugs may be covered. You'll likely need to pay out of pocket for the drugs and send in a claim to your drug plan for a refund.

- Generally, your Medicare drug plan won't pay for over-the-counter drugs, like Tylenol®
- The drug you need must be on your drug plan's formulary (list of covered drugs)
- You can't get your self-administered drugs in an outpatient or emergency department setting on a regular basis
- Your Medicare drug plan will check to see if you could've gotten these self-administered drugs from an in-network pharmacy
- If the hospital pharmacy doesn't participate in Medicare, you may need to pay out of pocket for these drugs and submit the claim to your Medicare drug plan for reimbursement

NOTE: Visit medicare.gov/pubs/pdf/11333-How-Medicare-Covers-Self-Administered-Drugs-in-Hospital-Outpatient.pdf to download the tip sheet "How Medicare Covers Self-administered Drugs Given in Hospital Outpatient Settings" (CMS Product No. 11333).

Medicare Prescription Drug Coverage (Part D)

- Medicare drug plans
  - Approved by Medicare
  - Run by private companies
  - Available to everyone with Medicare
- You must join a plan to get coverage
- There are 2 ways to get Medicare drug coverage
  - Medicare Prescription Drug Plans
  - Medicare health plans with prescription drug coverage

Medicare Prescription Drug Coverage

AD ASTRA

Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for medically necessary brand-name and generic prescription drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. All people with Medicare are eligible to enroll in a Medicare drug plan. To get coverage, you must join a plan–enrollment isn't automatic for most people. There are 2 main ways to get Medicare prescription drug coverage:

1. Join a Medicare Prescription Drug Plan (PDP). These plans add coverage to Original Medicare, and may be added to some other types of Medicare health plans (but not to Medicare Advantage (MA) Plans).
2. Join an MA Plan with prescription drug coverage (MA-PD) (like a Health Maintenance Organization or a Preferred Provider Organization) or another Medicare health plan, like a Medicare Cost Plan that includes Medicare prescription drug coverage. You'll get all your Medicare coverage (Part A and Part B), and your prescription drug coverage (Part D) through these plans.

The term "Medicare drug plan" is used throughout this presentation to mean both PDPs and MA-PDs or other Medicare plans with prescription drug coverage.

NOTE: Some Medicare Supplement Insurance (Medigap) policies offered prescription drug coverage before January 1, 2006. This isn't Medicare prescription drug coverage.

For more information, read "Your Guide to Medicare Prescription Drug Coverage" at Medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.

Medicare Part D Drug Coverage (cont.)

- Can offer different combinations of coverage and cost-sharing
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment levels
  - Deductible
- Benefits and costs may change each year

Medicare Prescription Drug Coverage

AD ASTRA

Medicare drug plans may be different from each other in terms of which prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must give at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Plans may offer more coverage and additional drugs, generally for a higher monthly premium.
Most plans will have a difference in offered benefits (costs that will vary), including tiers, copayments, and/or deductibles. Enhanced plans may offer additional benefits, like coverage in the coverage gap or coverage for drugs that Medicare Part D doesn't traditionally cover.

Plan benefits and costs may change each year, so it's important to look at and compare your plan options annually.

Part D Eligibility Requirements

- You must have Medicare Part A and/or Part B to join a Medicare Prescription Drug Plan
- You must have Medicare Part A and Part B to join a Medicare Advantage Plan with drug coverage
- You must have Medicare Part A and Part B or only Part B to join a Medicare Cost Plan with Part D coverage
- You must live in the plan's service area
  - You can't be incarcerated
  - You can't be unlawfully present in the U.S.
  - You can't live outside the United States
- You must join a plan to get drug coverage (in most cases)

Medicare Prescription Drug Coverage

AD ASTRA

To join a Medicare Prescription Drug Plan (PDP), you must have Medicare Part A and/or Part B. To join a Medicare Advantage Plan with prescription drug coverage (MA-PD), you must have both Medicare Part A and Part B. To join a Medicare Cost Plan with prescription drug coverage, you must have Medicare Part A and Part B, or have Medicare Part B only.

Each plan has its own service area, which you must live in to enroll. People in the United States territories, including Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa can enroll. If you live outside the United States and its territories, or if you're incarcerated, you're not eligible to enroll in a plan. This means you can't get Part D coverage. You must be lawfully present in the U.S. to be eligible to enroll in a plan.

Medicare drug coverage isn't automatic. Most people must join a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, you need to take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare drug plan unless you decline coverage or join a plan yourself. You can only be a member of one Medicare drug plan at a time.

Creditable Drug Coverage

- Other current prescription drug coverage
  - For example, from group health plans (GHP) like from an employer, retiree plans, Veterans Affairs (VA), TRICARE, the Indian Health Service (IHS), and the Federal Employee Health Benefits (FEHB) Program
- Creditable if it pays, on average, as much as Medicare's standard drug coverage
- Plans inform yearly about whether creditable or not
- Any lapse of 63 days or more in creditable coverage, and you may have to pay a late enrollment penalty when you enroll Medicare prescription drug coverage

AD ASTRA

Medicare Prescription Drug Coverage

To avoid paying a penalty if you become eligible for Medicare and don't enroll in a Medicare drug plan, you must have other creditable prescription drug coverage—coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. It could include drug coverage from a former employer or union, TRICARE, Veterans Affairs (VA), the Federal Employees Health Benefits (FEHB) Program, or the Indian Health Service (IHS). If you have other prescription drug coverage, you'll get information each year from your plan that tells you if your coverage is "creditable" or "non-creditable." Your plan must send you this written disclosure prior to October 15th each year, or at other times during the year if there's a change. Keep this information because you'll need it if you join a Medicare drug plan later.

If you have creditable coverage, you can generally keep that coverage and you won't have to pay a penalty if you decide to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends.

NOTE: Most Medicare Supplement Insurance (Medigap) policies that have drug coverage were sold prior to January 1, 2006. They don't meet Medicare's minimum standards—that is, they don't provide creditable coverage. If you have a Medigap policy that covers drugs, you can keep your policy, but you may have to pay a penalty if you wait to join a Medicare drug plan. If you decide to join a Medicare drug plan, you'll need to tell your Medigap insurer when your coverage starts, so your insurer can remove prescription drug coverage from your Medigap policy.

Potential Loss of Other Coverage

- If you have coverage through other insurance
  - For example, from group health plans (GHP) like from an employer, retiree plans, or Program of All-Inclusive Care for the Elderly (PACE)
- Joining a Medicare drug plan could cancel your (and any dependents that might be on your plan) other coverage
  - You could lose both your health and drug benefits
  - You may not be able to get your coverage back
- Check with your current plan before enrolling

Medicare Prescription Drug Coverage

AD ASTRA

In some retiree plans, if you join a Medicare drug plan, you and any dependents could lose their retiree health and drug coverage. Usually, once this happens, you can't get these benefits back. Talk with your plan's benefits administrator before enrolling in a Medicare drug plan.

If you join a Program of All-Inclusive Care for the Elderly (PACE), you'll get your Part D-covered drugs and all other necessary medication from the PACE program. You don't need to join a separate Medicare Prescription Drug Plan. If you do, you'll be disenrolled from your PACE health and prescription drug benefits.

Similarly, if you're in a Medicare Advantage Plan with prescription drug coverage (MA-PD), and you join a stand-alone Medicare prescription drug plan (PDP), in most cases, you'll be disenrolled from your MA-PD and returned to Original Medicare.

Initial Enrollment Period (IEP)

- When you first become eligible to get Medicare
  - 7-month IEP for Part D

If You Join	Coverage Begins
During the 3 months before you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months after you turn 65	First day of the month after month you apply

Medicare Prescription Drug Coverage

When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D:

- You can apply as early as 3 months before your month of Medicare eligibility. Coverage will start on the date you become eligible for Medicare.
- If you apply during your month of eligibility, then your Medicare drug coverage begins the first day of the following month.
- You can apply during the 3 months after your month of eligibility, with coverage beginning the first day of the month after the month you apply.

Some groups of people who become eligible to get Medicare will be enrolled in a Medicare drug plan by CMS (because they qualify for Extra Help) unless they join a plan on their own.

NOTE: If you get Social Security or Railroad Retirement benefits when you turn 65, you'll be enrolled automatically in Medicare Part A and Part B. However, you'll still need to choose and enroll in Part D during your IEP if you'd like to have Medicare drug coverage. If you enroll later, you may pay a late enrollment penalty and have a gap in coverage.

Other Enrollment Periods

- Medicare's yearly Open Enrollment Period (OEP) is October 15–December 7 each year, coverage starts January 1
  - Can make changes to your Medicare coverage
- MA OEP is January 1–March 31 each year (have to be enrolled in an MA Plan as of January 1)
  - Can add or drop Part D when switching plans
  - Part D not guaranteed unless you were in an MA Plan on January 1
  - Can't switch from one standalone PDP to another standalone PDP
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (GEP) (January 1–March 31), you can sign up for a Medicare PDP from April 1–June 30 each year

Medicare Prescription Drug Coverage

AD ASTRA

Medicare's Open Enrollment Period (OEP) runs from October 15–December 7 each year, with changes going into effect on January 1. During this time you can make changes to your Medicare coverage.

The MA OEP started in 2019. It's from January 1–March 31 each year. Your coverage begins the first day of the month after you enroll in the plan. You must be in an MA Plan already on January 1 to use this enrollment period. If you're switching plans, don't disenroll from your current plan. Instead, call to enroll in the new plan and this will automatically disenroll you from the old plan.

If you're in an MA Plan on January 1, you can use the MA OEP to do the following:

- Switch MA Plans
- Leave MA to join Original Medicare
  - There's a coordinating Part D Special Enrollment Period (SEP)
- Add or drop Part D when switching plans

However, getting Part D isn't guaranteed unless you were in an MA Plan on January 1. You can't use the MA OEP to do the following:

- Switch from one standalone PDP to another standalone PDP
- Join MA if in Original Medicare
  - If you don't have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (GEP) (January 1–March 31), you can sign up for a Medicare PDP from April 1–June 30. Your coverage begins on July 1.

Special Enrollment Period (SEP)

- Life events that allow an SEP include
  - You permanently move out of your plan's service area
  - You lose other creditable prescription coverage
  - You weren't properly told that your other coverage wasn't creditable, or your other coverage was reduced and is no longer creditable
  - You enter, live at, or leave a long-term care facility
  - You have an SEP to change plans once each quarter of the first three quarters of the year if you qualify for Extra Help
  - You belong to a State Pharmaceutical Assistance Program
  - You join or switch to a plan that has a 5-star rating
  - Other exceptional circumstances

Medicare Prescription Drug Coverage

AD ASTRA

You can make changes to your Medicare prescription drug coverage when certain events happen in your life. These chances to make changes are called Special Enrollment Periods (SEPs). Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year. The SEPs listed below are examples. The list doesn't include every situation:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you weren't properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable
- If you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help, you have an SEP, and can change your Medicare drug plan once every quarter for the first three quarters of the year
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating
- Other exceptional circumstances, like if you no longer qualify for Extra Help

NOTE: It's important to remember that the SEPs for Part B and Part D have different time frames for when you need to sign up for coverage. You may be eligible for a Medicare Part B SEP if you're over 65 and you (or your spouse) are still working and have health insurance through active employment. Your Part B SEP lasts for 8 months and begins the month after your employment ends. However, your Part D SEP lasts for only 2 full months after the month your coverage ends.

SEP options will display for you if you enroll through the Medicare Plan Finder on Medicare.gov. By checking any of the listed SEPs, you're certifying that, to the best of your knowledge, you're eligible for an enrollment period. If at a later time it's determined that this information was incorrect, you may be disenrolled from the plan.

Extra Help, Dual and Partial Dual Eligible Special Enrollment Period (SEP) Limitations

- Previously, the SEP for those eligible for Extra Help (also known as LIS), dual eligible, and partial duals was ongoing
- As of January 1, 2019
  - Can only change plans one time per calendar quarter in the first 3 quarters of the year (January–March, April–June, and July–September)
    - Annual OEP can be used in the fourth quarter
  - These individuals will have another 3-month SEP following
    - A gain, loss, or change to Medicaid or Extra Help status
    - Notification of a CMS or state-initiated enrollment action
  - Extra Help, dual and partial dual eligible individuals who are determined to be "potentially at-risk" or "at-risk" for misuse of frequently abused drugs won't be able to use this SEP (1x per calendar quarter SEP) to change plans

Medicare Prescription Drug Coverage

AD ASTRA

As of January 1, 2019, those who are eligible for both Medicare and Medicaid (also called "dual eligible" or "dual"), those who get cost sharing assistance under Medicaid (Medicare Savings Program; sometimes called "partial duals") and those who get Extra Help (also known as LIS) can change plans one time per calendar quarter in the first 3 quarters of the year. Rule CMS-4182-F finalized this SEP. Those who are identified as "at-risk" or "potentially-at-risk" can't use this SEP. The SEP starts the date of notification of the change. People can enroll up to the last day of the SEP and coverage starts the 1st day of the following month.

To change plans in the fourth quarter, a person with Medicare and Medicaid would use the OEP. Also, Extra Help, dual eligible, and partial dual individuals will have another 3-month SEP following

- A gain, loss, or change to Medicaid or Extra Help status
- Notification of a CMS or state-initiated enrollment action

And, finally, those duals/Extra Help eligibles who are determined to be "potentially at-risk" or "at-risk" for misuse of frequently abused drugs won't be able to use the duals/Extra Help SEP (1x per calendar quarter SEP) to change plans.

The "quarterly" SEP is the only SEP that "potentially at-risk" or "at-risk" individuals can't use. These individuals can still use the SEPs due to a gain, loss, or change in Medicaid or Extra Help and upon notification of a CMS or state-initiated enrollment to change plans, and they can also use the OEP or any other SEP for which they meet the criteria, like if they move out of the service area.

For more information about this SEP (42 CFR 423.38(c)(4)), see Chapter 3 of the Medicare Prescription Drug Benefit Manual at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY_2019_PDP_Enrollment_and_Disenrollment_Guidance.pdf.

Extra Help and Dual Eligible Special Enrollment Period (SEP) Limitations (continued)

- Comprehensive Addiction and Recovery Act (CARA) established drug management programs
- Individuals who have been notified that that they're "potentially at-risk" or "at-risk" under a drug management program can't use the Extra Help and Dual Eligible SEP
  - Limitation lasts until the "at-risk" determination expires or is terminated by the plan
  - "At-risk" status can be appealed to plan
  - Decision based on opioid use, dosage, and number of providers used
- Other enrollment periods are still available—OEP, other SEPs

Medicare Prescription Drug Coverage

AD ASTRA

There's a new limitation for people with Medicare who are considered "at-risk" or "potentially at-risk" for opioid misuse. Once an individual is identified by a Medicare drug plan as a "potentially at-risk" or "at-risk" person with Medicare, under a drug management program, he or she can't use this SEP to change plans for as long as he or she is considered as "potentially at-risk" or "at-risk." Determination of who's at risk depends on a person's opioid use, dosage, and the number of providers used. It's important to note that 75% of "at-risk" individuals are dual eligible or Extra Help (also called low-income subsidy or LIS) recipients. Those determined "at-risk" or "potentially at-risk" are still eligible for other enrollment periods provided they meet the criteria.
Notification of Limitation – Once a plan identifies a person with Medicare as "potentially at-risk," under a drug management program, the plan, with limited exception, is required to provide an initial notice to the person which includes notification that this SEP is no longer available.
Duration of Limitation – The duals' SEP limitation will be effective as of the date on the initial notice provided to the "potentially at-risk" individual. If the Part D plan takes no additional action to identify the individual as "at-risk" within 60 days from the date on the initial notice, the "potentially at-risk" designation and the duals' SEP limitation will expire.
Once identified as "at-risk," the duals SEP limitation will expire when there's subsequent determination, including but not limited to, a successful appeal, that the individual is no longer "at-risk," or, an initial 12-month period, with the option to extend for a maximum of 24 months in total (that is, an additional 12-month period) upon reassessment of the person's "at-risk" status at the completion of the initial 12-month period, whichever happens first.
For more information, see the fact sheet at CMS.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program.

New Part D Special Enrollment Periods (SEPs)

- SEPs established for the following groups:
  - Those who have been assigned into a plan by CMS/state(s) (e.g., auto-assignment, reassignment, passive enrollment)
  - Those who gain, lose, or have a change in their dual (including partial duals) or Extra Help status
- SEPs are separate from the dual/Extra Help SEP
- Available for "at-risk" individuals

Medicare Prescription Drug Coverage

AD ASTRA

As of January 1, 2019, CMS rule CMS-4182-F also established Part D SEPs for the following groups:

- Those who have been assigned into a plan by Medicare or their state, for instance through auto-assignment, reassignment, and passive enrollment
- Those (full or partial duals) who gain, lose, or have a change in their dual eligible (Medicaid) or Extra Help status
- SEPs start upon notification of the assignment to another plan or the notification of the change in Extra Help or dual eligibility
- SEPs end 3 months after notification or change in status/assignment into a plan, whichever is later
- Coverage would start 1st day of the month following election

These SEPs are separate from the typical dual eligible or Extra Help SEP. They are also available for "at-risk" individuals.

For more information about these SEPs (42 CFR 423.38(c) (10) and 42 CFR 423.38(c) (9)), see Chapter 3 of the Medicare Prescription Drug Benefit Manual at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/CY_2019_PDP_Enrollment_and_Disenrollment_Guidance.pdf.

5-Star Special Enrollment Period (SEP)

- Use Medicare Plan Finder tool at Medicare.gov to see quality and performance ratings
- Star ratings are given once a year in October for the past year
- Use 5-star SEP to switch to any 5-star plan one time
  - December 8–November 30 of following year
  - Coverage starts first day of month after enrolled
- Be careful not to switch from a Medicare Advantage (MA) Plan with drug coverage to an MA Plan with no Part D coverage
- You'd have to wait until the next enrollment period to get drug coverage and may have to pay a penalty

Medicare Prescription Drug Coverage

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars with a 5-star rating considered excellent.

Plans are assigned their star rating once a year, in October, for the upcoming calendar year. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this SEP. The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

You can use the 5-star SEP at any time during the year to enroll in a 5-star MA–only plan, a 5-star MA-PD, a 5-star PDP, or a 5-star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

CMS also created a coordinating SEP for Medicare PDPs. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a PDP, if that combination is allowed under CMS rules. You may use the 5-star SEP to change plans one time starting from December 8 (the day after the OEP ends) until November 30 of the next year. Once you enroll in a 5-star plan, your SEP ends for that year and you're allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the 1st day of the month following the month in which the plan gets your enrollment request.

You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that has no drug coverage. You'll have to wait until the next applicable enrollment period to get drug coverage and may have to pay a penalty.

Consistently Low Performing Plan

- Low performing star rating status
  - You may have a one-time option to switch to another Medicare drug plan with a rating of 3, 4, or 5 stars if your plan's summary rating was less than 3 stars for 3 years
  - Low Performance Icon (LPI) appears on Plan Finder
  - Plans may not attempt to discredit their LPI status by showcasing a separate higher rating

AD ASTRA

A plan that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years (that is, rated 2.5 or fewer stars for the 2016, 2017, and 2018 plan years for Part C or Part D) will be marked with the low performing icon on Medicare Plan Finder. Medicare sends the "Introduction to the Consistent Poor Performer," notice (CMS Product No. 11633), to members of these plans, giving them a one-time option to switch to another Medicare drug plan with 3 stars or better. Visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/Feb2015_LPI_Notice_CMS-11633.pdf to view the notice in English and Spanish.

The summary rating gives an overall score on the drug plan's quality and performance based on many topics arranged into 4 categories:

1. Drug plan customer service - includes how each plan performs in customer service. For example, it shows how well the plan handles member appeals.
2. Member complaints and changes in the drug plan's performance - includes how often members have problems and how often they choose to leave the plan. Also includes how much the plan's performance has improved (if at all) over time.
3. Member experience with the drug plan - includes how well each plan performed on Medicare's member experience survey.
4. Drug safety and accuracy of drug pricing - includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way considered safe and clinically recommended for their condition.

Medicare gathers the information from several different sources, including member surveys, billing information plans submit to Medicare, and results from Medicare's regular monitoring activities.

Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium ($32.74 in 2020)
    - For each full month eligible and not enrolled
  - Amount changes every year

Medicare Prescription Drug Coverage

AD ASTRA

If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. If you have creditable coverage when you first become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won't have to pay a late enrollment penalty if you get Extra Help paying for your prescription drugs.

The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium ($32.74 in 2020) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn't and went without other creditable prescription drug coverage. The penalty calculation isn't based on the premium of the plan in which you are enrolled. The final amount is rounded to the nearest $.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to provide proof that supports your case.

Part D Penalty Example—Ann

- Didn't join when she was first eligible—by May 31, 2017
- Has no drug coverage from any other source
- Joined a Medicare drug plan during the 2019 Open Enrollment Period
  - Her coverage begins on January 1, 2020
- Without creditable prescription drug coverage from June 2017–December 2019
- The penalty in 2019 is 31% (1% for each of the 31 months) of $32.74 (the national base beneficiary premium for 2020), which is $10.15
- The monthly penalty is rounded to the nearest $.10, so she'll be charged $10.20 each month in addition to her plan's monthly premium in 2020

Here's the math:

.31 (31% penalty) × $32.74 (2020 base beneficiary premium) = $10.15

$10.15 (rounded to the nearest $0.10) = $10.20

$10.20 = Ann's monthly late enrollment penalty for 2020

Medicare Prescription Drug Coverage

AD ASTRA

Ann didn't join when she was first eligible—by May 31, 2017. She doesn't have drug coverage from any other source. She joined a Medicare drug plan during the 2019 Open Enrollment Period. Her coverage will begin on January 1, 2020.

She was without creditable prescription drug coverage from June 2017–December 2019. Her penalty in 2020 is 31% (1% for each of the 31 months) of $32.74 (the national base beneficiary premium for 2020), which is $10.15. The monthly penalty is rounded to the nearest $.10, so she'll be charged $10.20 each month in addition to her plan's monthly premium in 2020.

Here's the math:

- **.31** (30% penalty) × **$32.74** (2019 base beneficiary premium) = **$10.15**
- **$10.15** (rounded to the nearest $0.10) = **$10.20**
- **$10.20** = **Ann's monthly late enrollment penalty for 2020**

After she joins a Medicare drug plan, the plan will tell her if she owes a penalty, and what her premium will be. She may have to pay this penalty for as long as she has a Medicare drug plan. If she had to pay a Part D late enrollment penalty before she turned 65, the penalty would be waived once she reaches 65.

The base beneficiary premium changes each year. This means that each year Medicare will use the current coverage year's amount to calculate a person's new penalty amount. If she becomes eligible for Extra Help, she would no longer have to pay the penalty.

Medicare Drug Plan Costs

- Costs vary by plan
- In 2020, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 25% for covered drugs in the coverage gap (after $4,020)
  - Very little after spending $6,350 out of pocket — automatically get catastrophic coverage

Medicare Prescription Drug Coverage

AD ASTRA

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, like which drugs you use, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs. Most people will pay a monthly premium for Medicare prescription drug coverage. You'll also pay a share of your prescription costs, including a deductible (if applicable), copayments, and/or coinsurance.

You can choose how you want to be billed when you enroll in the plan. One option is to have your premium deducted from your monthly Social Security or Railroad Retirement Board (RRB) payment. Contact your plan (not Social Security or RRB). Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once. After that, only one premium will be deducted each month.

If you switch plans, you may see a delay in premiums being withheld. If you want to stop premium deductions and get billed directly, contact your drug plan. For additional information, visit Medicare.gov/pubs/pdf/11400-Withholding-Medicare-Drug-Premium.pdf.

In 2020, once you and your plan have spent $4,020 for covered drugs, you're in the coverage gap (also called the "donut hole"). The coverage gap is a temporary limit on what the drug plan will cover for drugs. You leave the coverage gap once you and your plan have spent $6,350 and you automatically get catastrophic coverage.

Part D Standard Benefit

Ms. Smith joins a Medicare Prescription Drug Plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

1. Yearly deductible	2. Copayment or coinsurance (what you pay at the pharmacy)	3. Coverage gap	4. Catastrophic coverage
Ms. Smith pays the first $435 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $4,020 (Initial Coverage Limit).	Once Ms. Smith and her plan have spent $4,020 for covered drugs, she's in the coverage gap. Beginning in 2020, she gets a 70% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2020, she gets an additional 5% coverage from her plan on covered brand-name drugs and 75% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent $6,350 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Medicare Prescription Drug Coverage

Here's an example showing what you'd pay each year in a standard Medicare Prescription Drug Plan. Not all plans follow this design. Your drug plan costs will vary.

- **Monthly premium**—Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to a Medicare Advantage Plan that includes drug coverage, the monthly plan premium may include an amount for prescription drug coverage.
- **Yearly deductible (you pay up to $435 in 2020)**—This is the amount you pay each year for your prescriptions before your plan begins to pay. No Medicare drug plan may have a deductible more than $435 in 2020. Some drug plans don't have a deductible.
- **Copayments or coinsurance (you pay approximately 25%)**—These are the amounts you pay for your covered prescriptions after you pay the deductible (if the plan has one). You pay your share and the drug plan pays its share for covered drugs. (Initial Coverage Limit)
- **Coverage gap**—The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs ($4,020 in 2020). In 2020, once you enter the coverage gap, you pay 25% of the plan's cost for your covered drugs (may include a dispensing fee) until you reach the end of the coverage gap. Certain costs count toward getting out of the coverage gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the gap, and what you pay in the gap. However, the drug plan premium, what you pay for drugs that aren't covered, the discount for covered generic drugs in the coverage gap, and the dispensing fee don't count toward getting you out of the coverage gap.
- **Catastrophic coverage**—Once you reach your out-of-pocket limit ($6,350 in 2020), you leave the coverage gap, and automatically get catastrophic coverage, where you only pay a 5% coinsurance or small copayment, whichever is higher, for covered drugs for the rest of the year.

NOTE: If you get Extra Help, you won't have some of these costs.

Improved Coverage in the Coverage Gap

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2019	25%	37%
2020	25%	25%

AD ASTRA

Once you reach the coverage gap in 2020, you'll pay 25% of the plan's cost for covered prescription drugs. You get these savings if you buy your prescriptions at a pharmacy or order them through the mail. The discount will come off of the price that your plan has set with the pharmacy for that specific drug. In 2020, 95% of the price of brand-name drugs—what you pay plus the 70% manufacturer discount payment—will count as out-of-pocket costs, which will help you get out of the coverage gap. What the drug plan pays toward the drug cost (5% of the price) and what the drug plan pays toward the dispensing fee (55% of the fee) aren't counted toward your out-of-pocket spending.

In 2020, Medicare will pay 75% of the price for generic drugs during the coverage gap. You'll pay the remaining 25% of the price. What you pay for generic drugs during the coverage gap decreased each year since 2012 until it reached 25% in 2020. The coverage for generic drugs works differently from the discount for brand-name drugs. For generic drugs, only the amount you pay will count toward getting you out of the coverage gap.

H.R.1892 - Bipartisan Budget Act of 2018 – enacted 2/9/2018 - institutes three key changes to Medicare Part D's "donut hole" (Coverage Gap) for applicable beneficiaries, effective January 1, 2019:

1. Closes the coverage gap one year early for applicable drugs, reducing standard beneficiary cost sharing in that phase from 30% to 25%

2. Increases pharmaceutical manufacturers' discount in the Coverage Gap Discount Program (CGDP) from 50% to 70% of the negotiated price of applicable drugs, resulting in lower costs to Part D plan sponsors

True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($6,350 in 2020)
- After threshold you get catastrophic coverage
  - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year

Medicare Prescription Drug Coverage

AD ASTRA

True out-of-pocket (TrOOP) costs are the amounts you pay for covered Part D drugs that count towards your drug plan's out-of-pocket threshold of $6,350 (for 2020). Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium. TrOOP costs determine when your catastrophic coverage begins. Your drug plan will keep track of your TrOOP costs. Each month that you buy prescriptions covered by your plan, your drug plan will mail you an Explanation of Benefits (EOB) showing your TrOOP costs to date.

For payments to count toward your TrOOP costs, they must be made by you or on your behalf, not be covered by other insurance, and be for certain types of costs according to your plan rules (for example, drugs that are on the plan's formulary or filled at a pharmacy in the plan's network).

If you switch plans during the year, your TrOOP balance transfers to the new Medicare drug plan. Medicare has put processes in place for transferring the TrOOP balance. The transfer begins when you disenroll and join a new plan. If you think there's a mistake in the TrOOP balance that's transferred, you may need to give a copy of your most recent EOB to the new plan to show the current TrOOP balance.

What Payments Count Toward TrOOP?

- **Payments made by**
  - You (including payments from your Medical Savings Account (MSA), Health Savings Account (HAS), or Flexible Spending Account (FSA) (if applicable))
  - Family members or friends
  - Qualified State Pharmacy Assistance Programs (SPAPs)
  - Medicare's Extra Help (low- income subsidy)
  - Indian Health Service (IHS)
  - Most charities (unless they're established, run, or controlled by the person's current or former employer or union or by a drug manufacturer's Patient Assistance Program operating outside Part D)
  - Drug manufacturer discounts on brand name/generic drugs under the Medicare Coverage Gap Program
  - AIDS Drug Assistance Programs (ADAPs)

Medicare Prescription Drug Coverage

AD ASTRA

True out-of-pocket (TrOOP) costs are the amounts you pay for covered Part D drugs that count toward your drug plan's out-of-pocket threshold of $6,350 for 2020. Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The monthly drug plan premiums you pay don't count towards the out-of-pocket limit. TrOOP costs determine when your catastrophic coverage begins. Your drug plan will keep track of your TrOOP costs. Each month that you buy prescriptions covered by your plan, your drug plan will mail you an Explanation of Benefits (EOB) showing your TrOOP costs to date.

For payments to count toward your TrOOP costs, you must make them or they must be made on your behalf. They can't be covered by other insurance, and must be for certain types of costs according to your plan's rules (for example, drugs on the plan's formulary or filled at a pharmacy in the plan's network). If you use your plan for every prescription, the plan can conduct proper safety checks and concurrent drug use reviews. You can ask your pharmacist if there's a less expensive option available. As a result of the Know the Lowest Price Act, your pharmacist can tell you if it's less expensive to pay for the drug out-of-pocket. You can also submit your receipts to your plan to have these costs counted to your yearly TrOOP balance. Check with your plan to find out how. For additional information about which claims may be reimbursable, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter-14-Coordination-of-Benefits-v09-17-2018.pdf.

If you switch plans during the year, your TrOOP balance transfers to the new Medicare drug plan. Medicare has processes in place for transferring the TrOOP balance. The transfer begins when you disenroll and join a new plan. If you think there's a mistake in the TrOOP balance that's transferred, you may need to give a copy of your most recent EOB to the new plan to show the current TrOOP balance.

What Payments Don't Count Toward TrOOP?

- The amount paid by a Medicare drug plan
- The monthly drug plan premium
- Drugs purchased outside the U.S. and its territories
- Drugs not covered by the plan
- Drugs excluded from the definition of Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Payments made by, or reimbursed to you by
  - Group health or retiree coverage
  - Government-funded programs
  - Other third-party groups
  - Patient Assistance Programs operating outside the Part D benefit
  - Other types of insurance
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

Medicare Prescription Drug Coverage

AD ASTRA

These payments **don't** count toward your True Out-of-Pocket (TrOOP) costs:

- The share of the drug cost paid by a Medicare drug plan (for 2020 5% for brand-name drugs and 75% for generics)
- Monthly drug plan premium
- Drugs purchased outside the United States and its territories
- Drugs not covered by the plan
- Drugs that are excluded from the definition of a Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy)

Payments **don't** count toward your TrOOP costs if they're made by (or reimbursed to you by) any of these:

- Group health plans like the Federal Employees Health Benefit Program or employer or union retiree coverage
- Government-funded health programs like Medicaid, TRICARE, Workers' Compensation, the Department of Veterans Affairs (VA), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), the Children's Health Insurance Program (CHIP), and black lung benefits
- Other third-party groups with a legal obligation to pay for the person's drug costs
- Patient Assistance Programs (PAPs) operating outside the Part D benefit
- Other types of insurance

Part D Monthly Premium and Income-Related Monthly Adjustment Amounts (IRMAA)

- Based on income above a certain limit
  - Fewer than 5% pay a higher premium
  - Uses same thresholds used to compute IRMAA for the Part B premium
  - Income as reported on your IRS tax return from 2 years ago
- Required to pay if you have Part D coverage
  - Failure to pay will result in disenrollment

Medicare Prescription Drug Coverage

A small group—less than 5% of all people with Medicare—may pay a higher monthly premium based on their income (as reported on their IRS tax return from 2 years ago). If your income is above a certain limit, you'll pay an extra amount in addition to your plan premium. Social Security uses income data from the Internal Revenue Service to figure out if you have to pay a higher premium. The income limits are the same as those for the Part B Income-Related Monthly Adjustment Amount (IRMAA).

Usually, the extra amount will be taken out of your Social Security check. If you don't have enough money in your Social Security check, or don't get a Social Security check, you'll be billed for the extra amount each month by either Medicare or the Railroad Retirement Board (RRB). This means that you'll pay your plan each month for your monthly premium and pay Medicare or RRB each month for your IRMAA amount. (In other words, you'd pay the Part D–IRMAA amount directly to the government and not to your plan.) This also applies if you get Part D coverage through your employer (but not through a retiree drug subsidy or other creditable coverage).

If you don't pay, you'll be disenrolled from your Medicare drug plan, even if you get your Part D coverage through a Medicare Advantage Plan or through an employer.

You must pay both the extra amount (the Part B IRMAA) and your plan's premium each month to keep Medicare prescription drug coverage.

If you have to pay an extra amount and you disagree (for example, if you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY: 1-800-325-0778. For more information, visit socialsecurity.gov/.

Source: SSA Publication No. 05-10536, "Medicare Premiums: Rules for Higher-Income Beneficiaries" at SSA.gov/pubs/EN-05-10536.pdf.

Income-Related Monthly Adjustment Amount (Part D-IRMAA)

Your Yearly Income in 2018			In 2020 You Pay
Filing an Individual Tax Return	Filing a Joint Tax Return	File married & separate tax return	
$87,000 or less	$174,000 or less	$87,000 or less	$0.00 + YPP
Above $87,000 up to $109,000	Above $174,000 up to $218,000	See below	$12.20* + YPP
Above $109,000 up to $136,000	Above $218,000 up to $272,000	See below	$31.50* + YPP
Above $136,000 up to $163,000	Above $272,000 up to $326,000	See below	$50.70* + YPP
Above $163,000 and less than $500,000	Above $326,000 and less than $750,000	Above $87,000 and less than $413,000	$70.00* + YPP
$500,000 and above	$750,000 and above	$413,000 and above	$76.40* + YPP

***IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.**

Medicare Prescription Drug Coverage

The Bipartisan Budget Act of 2018, Section 402—Income-Related Premium Adjustment for Parts B and D: Beginning in 2018, this provision mandated adjustments to the current laws' income-related premium policy. This provision adjusts the amounts of the income thresholds for determining IRMAA.

In 2020, you pay only your plan premium if your yearly income in 2018 was $87,000 or less for an individual, or $174,000 or less for a married couple.

For 2020, if you reported a modified adjusted gross income (MAGI) of more than $87,000 (individuals) or $174,000 (married individuals filing jointly) on your 2019 Internal Revenue Service (IRS) tax return (the most recent tax return information provided to Social Security by the IRS), you'll have to pay the Part D IRMAA in addition to your monthly Medicare drug plan premium (YPP).

Above $163,000 up to $500,000, and file an individual tax return, file a joint tax return with an income above $326,000 up to $750,000, you pay YPP and IRMAA of $70.00 per month.

IRMAA is adjusted each year. It is calculated on the annual beneficiary base premium.

NOTE: If you're married filing separately, but you lived with your spouse at any time during the taxable year, and your income is from $87,000 up to $413,000, you pay YPP and IRMAA of $70.00.

If your income changes for certain reasons, like divorce or retirement, you may be able to reduce your IRMAA. Visit ssa.gov/forms/SSA-44-EXT.pdf to view and print a copy of the Medicare Income-Related Monthly Adjustment Amount – Life-Changing Event form.

Part D Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan

Medicare Prescription Drug Coverage

AD ASTRA

Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the U.S. Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication.

Medicare covers prescription drugs, insulin, and biological products (e.g., antibodies, proteins, cells, etc.). Medicare also covers medical supplies associated with the injection of insulin, like syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists (formulary) for each plan must include a range of drugs in each prescribed category. All Medicare drug plans generally must cover at least 2 drugs per drug category, but the plans may choose which specific drugs they cover. Coverage and rules vary by plan, which can affect what you pay.

Even if a plan's prescription drug list doesn't include your specific drug, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes none of the drugs on your plan's drug list will work for your condition, you may ask for an exception.

Required Coverage

- All drugs in 6 protected categories
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)

Medicare Prescription Drug Coverage

AD ASTRA

Medicare drug plans must cover all drugs in 6 protected classes to treat certain conditions:

1. Cancer drugs
2. HIV/AIDS drugs
3. Antidepressants
4. Antipsychotics
5. Anticonvulsants
6. Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots). You or your health care provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs

Medicare Prescription Drug Coverage

AD ASTRA

By law, Medicare doesn't cover the following drugs:

- Drugs for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose, like morbid obesity).
- Erectile dysfunction drugs when used to treat sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which use the U.S. Food and Drug Administration approved the drugs. For example, a Medicare drug plan may cover an erectile dysfunction drug when used to treat an enlarged prostate (also known as benign prostatic hyperplasia, or BPH).
- Fertility drugs.
- Drugs for cosmetic or lifestyle purposes (for example, hair growth).
- Drugs for symptomatic relief of coughs and colds.
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations).
- Non-prescription drugs.

Plans may choose to cover excluded drugs at their own cost or share the cost with you.

Visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf (42 CFR 423.100) for more information on excluded drugs.

Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
4 or Specialty	Highest copayment or coinsurance	Unique, very high cost

Medicare Prescription Drug Coverage

Each Medicare drug plan has a formulary, which is a list of prescription drugs that it covers. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive)—Tier 1 drugs are generic drugs and are the same as their brand-name counterparts in safety, strength, quality, the way they work, how they're taken, and the way they should be used. They use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. They're less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration. Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2–Preferred brand-name drugs**—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drug**—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4–(or Specialty Tier)**—These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.

Formulary Changes

- Plans may only change categories and classes at the beginning of each plan year
  - May make maintenance changes during year
- Plans usually notify you 30 days before changes or when you request a refill and will provide you a month's refill
  - You may be able to continue to have your drug covered until the end of the calendar year
  - May ask for exception if other drugs don't work
- Plans may immediately (without notice and at any time)
  - Remove brand-name drugs and replace them with new generic drugs if they meet certain requirements
  - Remove drugs deemed unsafe by the FDA or withdrawn from the market by the manufacturer

Medicare Prescription Drug Coverage

AD ASTRA

Medicare drug plans may only change their therapeutic categories and classes in a formulary at the beginning of each plan year, or to account for new therapeutic uses and newly FDA-approved Part D-covered drugs. A plan year is a calendar year, January through December.

Medicare drug plans can make maintenance changes to their formularies, like replacing brand-name drugs with new generic drugs, or changing their formularies as a result of new information on drug safety or effectiveness. Starting with 2019 formularies, a Medicare drug plan that meets certain requirements may immediately remove a brand-name drug from its Part D formulary or change to brand-name drug's preferred or tiered cost-sharing when adding an equivalent new generic drug. Other changes must be made according to the prescribed approval procedures, and plans must give, starting in 2019, 30 (rather than 60) days' notice to the Centers for Medicare & Medicaid Services (CMS), State Pharmacy Assistance Programs (SPAPs), prescribers, network pharmacies, pharmacists, and affected plan members. Plans must also notify members at the time they request a refill and provide a month's refill of the affected drug. Plans making mid-year changes must also update applicable member communications materials, like revising their online formularies to be current on a monthly basis. You may be able to continue to have your drug covered until the end of the calendar year. You may ask for an exception if other drugs don't work.

Under Part D, no plan members should have their drug coverage discontinued or reduced for the rest of the plan year. However, this isn't the case when a drug is deemed unsafe by the FDA or when the manufacturer takes the drug off the market. In those cases, Medicare drug plans aren't required to get CMS approval or give 30 days' notice.

NEW Formulary Changes

Plans can immediately remove or change the price for a brand-name drug if

- It adds a therapeutically equivalent generic drug to formulary on the same or lower cost tier and with the same or less restrictive criteria
- The generic drug became available on the market after the plan submitted its initial formulary
- It notifies all plan members and prospective enrollees of change
- It provides advance notice to CMS and other specified entities before making the substitution
- It directly notifies the affected enrollees

AD ASTRA

Medicare Prescription Drug Coverage

Starting with 2019 formularies, a Medicare drug plan may immediately remove a brand-name drug from its Part D formulary or change the brand-name drug's preferred or tiered cost-sharing without meeting the deadlines and refill requirements provided that the drug plan does all of the following:

At the same time that it removes such brand-name drug or changes its preferred or tiered cost-sharing, it adds a therapeutically equivalent generic drug to its formulary on the same or lower cost-sharing tier and with the same or less restrictive utilization management criteria.

The drug plan previously could not have included such therapeutically equivalent generic drug on its formulary when it submitted its initial formulary for CMS approval because such generic drug was not yet available on the market.

Before making any permitted generic substitutions, the Part D plan provides general notice to all current and prospective enrollees in its formulary and other applicable enrollee communication materials advising them that:

Such changes may be made at any time when a new generic is added in place of a brand-name drug, and there may be no advance direct notice to the affected enrollees;

If such a substitution should occur, affected enrollees will receive direct notice including information on the specific drugs involved and steps they may take to request coverage determinations and exceptions.

Before making any permitted generic substitutions, the Part D plan provides advance general notice to CMS and other specified entities.

The drug plan provides notice of any such formulary changes to affected enrollees and CMS and other specified entities consistent with existing requirements. This would include direct notice to the affected enrollees.

Coverage Determination Request

- Initial decision by plan
  - Which benefits you're entitled to get
  - How much you have to pay for a benefit
  - You, your prescriber, or your appointed representative can request it
- Time frames for coverage determination requests may be
  - Standard (decision within 72 hours)
  - Expedited (decision within 24 hours) if life or health may be seriously jeopardized

Medicare Prescription Drug Coverage

AD ASTRA

A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered; whether you've met all the requirements for getting a requested drug; and how much you must pay for a drug.

You, your prescriber, or your appointed representative (see Appendix B) can ask for a coverage determination by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form available www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/downloads/ModelCoverageDeterminationRequestForm.pdf There are 2 types of coverage determinations: standard or expedited. Your request will be fast (expedited) if the plan determines, or if your doctor tells the plan that your life or health may be seriously jeopardized by waiting for a standard request.

A plan must give you its coverage determination decision as quickly as your health condition requires. After getting your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited (fast) determination. If your coverage determination request involves an exception, the time clock starts when the plan gets your doctor's supporting statement.

If a plan fails to meet these time frames, it must automatically forward the request and case file to the Independent Review Entity (IRE) (MAXIMUS) for review, and the request will skip over the first level of appeal (redetermination by the plan). MAXIMUS contact information is available at Medicarepartdappeals.com/.

Exception Requests

- 2 types of exceptions
  1. Formulary exceptions (a type of coverage determination)
     - Drug not on plan's formulary, or
     - Access requirements (for example, step therapy)
  2. Tier exceptions
     - For example, getting a tier 4 drug at tier 3 cost
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests
- Exception may be valid for rest of year

Medicare Rights and Protections

AD ASTRA

An exception is a type of coverage determination. There are 2 types of exceptions: tier exceptions (like getting a tier 4 drug at the tier 3 cost) and formulary exceptions (either coverage for a drug that's not on the plan's formulary, or relaxed access requirements).

If you want to make an exception request, you'll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception request. Prescribers may give the statement verbally (they may later need to provide the statement in writing) or in writing to the plan.

If your exception request is approved, the exception is valid for refills for the remainder of the plan year, as long as you remain enrolled in that plan, your doctor continues to prescribe the drug, and the drug remains safe for treating your condition. For more information about tiering exceptions and approvals, visit CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html.

A plan may choose to extend exception coverage into a new plan year. If it doesn't, it must say so in writing either at the time the exception is approved, or at least 60 days before the plan year ends. If your plan doesn't extend your exception coverage, you should think about switching to a drug on the plan's formulary, asking for another exception, or changing to a plan that covers that drug during Medicare's OEP (October 15 through December 7 each year).

NOTE: If you want to choose a representative to help you with a coverage determination or appeal, you and the person you want to help you must fill out the Appointment of Representative form (Form CMS-1696). You can get a copy of the form at CMS.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html. You can also appoint a representative with a letter signed and dated by you and the person helping you, but the letter must have all the information that's required on the Appointment of Representative form. You must send the form or letter in with your coverage determination or appeal request.

Rules That Plans Use to Manage Access to Drugs

Rule Name	Coverage Rule Description
Prior Authorization	▪ Enrollee or prescriber must contact plan and show prior authorization (PA) criteria are met before the drug will be covered ▪ Enrollee or prescriber may request an exception to PA criteria, which the plan must allow if medically necessary
Step Therapy	▪ Type of PA ▪ Must use alternative drug(s) on plan's list ▪ Enrollee or prescriber may request an exception if alternative drug(s): • Wouldn't work as well as requested drug, or would have adverse effect • Plan must allow exception if medically necessary
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Enrollee or prescriber may request an exception if quantity/dose restriction would be ineffective in treating the enrollee's condition or would have adverse effects ▪ Plan must allow exception if additional amount is medically necessary

Medicare Prescription Drug Coverage

Medicare drug plans manage access to covered drugs in several ways, including prior authorization (PA), step therapy, and quantity limits.

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, you, or your doctor, or other prescriber must first show the plan you meet the plan's CMS-approved criteria for that particular drug. Plans may do this to ensure you're using these drugs correctly. Contact your plan about its prior authorization requirements and talk with your prescriber.

Step therapy is a type of prior authorization. In most cases, you must first try a certain alternative drug(s) on the plan's drug list that has been U.S. Food and Drug Administration approved for treating your condition before you can move up a step to a more expensive drug. For instance, some plans may require that you first try a generic drug on their drug list before you can get coverage for a similar, more expensive brand-name drug.

Plans may **limit the quantity of drugs** they cover for safety and cost reasons over a certain time period. If you or your prescriber believes that a quantity limit isn't appropriate for your condition, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.

If you or your prescriber believe that a prior authorization, step therapy, or quantity limit requirement shouldn't apply to you because of your medical condition, you (with your prescriber's help) can contact the plan to request an exception to the rule.

How Plans Manage Unsafe Use of Opioids

Drug Management Programs (DMPs)	▪ If you get opioids from multiple prescribers and pharmacies, your plan may talk with your doctor(s) to make sure you need these medications and you're using them safely. ▪ If your plan decides your use isn't safe, they may limit your coverage of these drugs and place you in its DMP. You'll get a letter in advance, and a second confirmation letter that includes the appeal process. ▪ If you believe this is a mistake, you or your prescriber may appeal the decision.
Safety Reviews at the Pharmacy	▪ An alert triggers at the pharmacy for potentially unsafe amounts, use of opioids with benzodiazepines, or new opioid use. ▪ If your pharmacy can't fill a prescription, the pharmacist will issue a notice explaining that you or your prescriber can contact the plan to request a coverage determination.

Medicare Prescription Drug Coverage

Medicare drug plans monitor the safe and effective use of prescription drugs including opioids and benzodiazepines. Opioid pain medications, like oxycodone and hydrocodone, are used to relieve pain for patients with active cancer or in hospice. Opioids can help with other types of pain in the short term, but have serious risks like addiction, overdose, and death. According to the National Institute of Health (NIH), over 30% of opioid overdoes also involve benzodiazepines, a type of prescription sedative commonly prescribed for anxiety and insomnia. **Source**: drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids.

As of January 1, 2019, most Medicare drug plans have a drug management program (DMP). If you get opioids from multiple doctors or pharmacies, your plan may talk with your doctors to make sure you need these medications and that you're using them safely. If your Medicare drug plan decides your use of prescription opioids and benzodiazepines isn't safe, the plan may limit your coverage of these drugs. For example, under its DMP, your plan may require you to get these medications only from certain doctors or pharmacies to better coordinate your health care.

Before your Medicare drug plan places you in its DMP, it will notify you by letter. You'll be able to tell the plan which doctors or pharmacies you prefer to use to get your prescription opioids and benzodiazepines. After you've responded, if your plan decides to limit your coverage for these medications, it will send you another letter confirming its decision and informing you of the appeal process. You and your doctor can appeal if you disagree with your plan's decision or think the plan has made a mistake.

Your Medicare drug plan and pharmacist will do safety reviews of your opioid pain medications when you fill a prescription. They'll review for potentially unsafe amounts, taking opioids with benzodiazepines like Xanax®, Valium®, and Klonopin®, and new opioid use (you may be limited to a 7-day supply or less). These reviews are especially important if you have more than one doctor who prescribes these drugs. In some cases, the Medicare drug plan or pharmacist may need to first talk to your doctor.

If your pharmacy can't fill your prescription as written, including the full amount on the prescription, the pharmacist will give you a notice explaining how you or your doctor can contact the plan to ask for a coverage decision. If your health requires it, you can ask the plan for a fast coverage decision. You may also ask your plan for an exception to its rules before you go to the pharmacy, so you'll know if your plan will cover the medication.

NOTE: DMPs and safety reviews generally don't apply to you if you have cancer, get hospice, palliative or end-of-life care, or if you live in a long-term care facility.

NEW Requirements for Medicare Drug Plans

- Effective January 1, 2019
- Medicare drug plans must
  - Reject or require a pharmacy benefit manager to reject a pharmacy claim for a Part D drug if the prescriber's included on the "Preclusions List" (e.g., certain individuals and entities that are currently revoked from the Medicare Program)
  - Deny payment for a service or item if the provider submitting the claim is on the "Preclusions List"
- CMS believes that a Preclusion List requirement will reduce the burden on Part D prescribers and Medicare Advantage (MA) providers without compromising program integrity efforts

Medicare Prescription Drug Coverage

MEASTRA

Effective January 1, 2019, Part D plans will be required to reject a pharmacy claim (or deny an enrollee request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List, and Medicare Advantage (MA) Plans will be required to deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

The Preclusion List is a list of individuals who fall within either of the following categories: (1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare Program; or (2) Have engaged in behavior for which CMS could've revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

For more information, visit CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

NEW The Preclusion List

- Providers will be notified of their potential inclusion on the list and their applicable appeal rights
- One Preclusion List with subsequent updates
  - Initial list available January 1, 2019
  - Updates made every 30 days (1st business day of each month)
  - Visit CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html for Preclusion List resources
- Medicare health plans and Part D plans must
  - Remove any contracted providers and pharmacies on the list from their networks
  - Notify enrollees who got care in the last 12 months from a contracted provider or a prescription from a provider who's included on the list

Medicare Prescription Drug Coverage

AD ASTRA

Prior to being added to a Preclusion List, providers will be notified by CMS of their potential inclusion on the Preclusion List and their applicable appeal rights. CMS will add a provider to the Preclusion List only if the provider's appeal is denied at the CMS level or the timeframe for the provider to request a CMS level appeal has been exhausted.

There's one Preclusion List with subsequent updates. CMS made the initial Preclusion List available to Medicare health plans and Part D plans on January 1, 2019, on a secure website. Updates to the Preclusion List are made every 30 days, around the 1st business day of each month. Visit CMS.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html to review the "User Reference Guide for CMS Preclusion List" for instructions on how to access the list. Additional resources located on this site include, Preclusion List FAQs, a CMS Preclusion List File Layout, and a CMS List Sample File.

Medicare health plans must remove any contracted provider who's included on the Preclusion List from their network as soon as possible. Part D plans are also expected to remove any precluded pharmacy from their network as soon as possible. Medicare plans and Part D plans should review the Preclusion List for this purpose on a regular basis.

Medicare health plans and Part D plans are required to immediately notify enrollees who got care in the last 12 months from a contracted provider or a prescription from a provider who's included on the Preclusion List.

NEW The Preclusion List—Beneficiary Notice

- CMS recommends that Medicare health and Part D plans
  - Provide Medicare enrollees with 60 days' advance notice before payment is denied or pharmacy claims are rejected
  - Began payment denials and claims rejections on April 1, 2019, for the January 1, 2019, Preclusion List
    - Allows 30 days for plans to review the list and notify Medicare enrollees, but no later than 30 days from the posting of the list and an additional 60 days for people with Medicare to prepare
  - Not reimburse or make payment for claims (like, for covered items or services) or prescriptions related to any providers included on the initial Preclusion List for dates of service on or after April 1, 2019 (includes emergency or urgent care circumstances)
  - Follow the same process for monthly updates to the Preclusion List as they did for the initial list

APRIL 2019
1

Medicare Prescription Drug Coverage

AD ASTRA

CMS acknowledges that the relevant enrollee notification and claim adjudication timeframes in CMS-4182-F are not consistent within the preamble and regulation. CMS finalized rule CMS-4185-F which clarified these timeframes and goes into effect on January 1, 2020.

For 2019, CMS recommends that Medicare health plans and Part D plans furnish Medicare enrollees with at least 60 days' advance notice before they begin denying payment for a health care item or service furnished by a provider on the Preclusion List and rejecting a pharmacy claim (or denying the person's request for reimbursement) for a drug that is prescribed by a provider on the Preclusion List. Payment denials and claims rejections began on April 1, 2019, for the January 1, 2019, Preclusion List. This allows 30 days for plans to review the Preclusion List and notify Medicare enrollees as soon as possible, but no later than 30 days from the posting of the list and an additional 60 days for people with Medicare to prepare. Medicare plans and Part D plans may not reimburse or make payment for claims (like, for covered items or services) or prescriptions associated with any providers on the initial Preclusion List for dates of service on or after April 1, 2019, including for emergency or urgent care circumstances.

CMS recommends that Medicare health plans and Part D plans follow the same process for monthly updates to the Preclusion List as they did for the initial list. The plans will have 30 days to review the Preclusion List for updates and should notify the impacted enrollees as soon as possible, but no later than 30 days from the posting of the updated list. Medicare enrollees should be given at least 60 days' advance notice before payment denials and claims rejections begin.

Medicare plans and Part D plans may notify providers included on the Preclusion List by copying the provider on the notice sent to the enrollee or by other means. This will notify providers about their patients who are impacted by their preclusion from the Medicare program.

Requirement for Prescribers

- New requirements for prescribers of Part D drugs will be in effect in 2019
- Prescribers must
  - Be enrolled in Medicare in an approved status, or
  - Have a valid opt-out affidavit on file, or
  - Be a pharmacist with prescribing authority

Medicare Prescription Drug Coverage

AD ASTRA

CMS is using prescription drug event data to guide efforts to combat fraud and abuse and sharing the results of data analysis with Part D plan sponsors, law enforcement agencies, and pharmacy and physician licensing boards, as appropriate.

In 2019, CMS will implement key fraud and abuse provisions that will require prescribers of Part D drugs to enroll in Medicare. CMS finalized CMS-4159-F "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 23, 2014, and is delaying enforcement until 2019. This rule will require doctors and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status, or to have a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor (MAC) for their prescriptions to be covered under Part D. If they haven't enrolled or opted out, affected enrollees will get a 3-month supply of the drug prescribed with a written notice explaining that the drug will no longer be covered after that unless the prescriber meets the requirements.

NOTE: Part B MACs handle enrollment functions for doctors and other prescribers. CMS offers an enrollment file that identifies doctors and eligible professionals enrolled in Medicare in an approved or opt-out status at data.CMS.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. For more information, visit CMS.gov /Outreach-and-Education/Medicare-Learning-Network-LN/MLNMattersArticles/downloads/SE1434.pdf.

If Your Prescription Changes

- Get up-to-date formulary information from your plan's
  - Website
  - Customer service center
- Give your doctor a copy of plan's formulary if it isn't prescribed electronically
- If the new drug isn't on the plan's formulary
  - You can request an exemption from the plan
  - You may have to pay full price if plan still won't cover
  - You may consider changing your Part D plan when permissible to one that does cover

Medicare Prescription Drug Coverage

AD ASTRA

Plans can change their drug list and prices for drugs. Call your plan's customer service center, or look on your plan's website to find the most up-to-date Medicare drug list and prices.

Your doctor or other prescriber may need to change your prescription or prescribe a new drug. If your doctor prescribes electronically, they can check which drugs your drug plan covers through their electronic prescribing system. If your doctor doesn't prescribe electronically, give them a copy of your Medicare drug plan's current drug list (formulary).

If your doctor needs to prescribe a drug that's not on your Medicare drug plan's drug list and you don't have any other health insurance that covers outpatient prescription drugs, you or your doctor can ask the plan for an exception.

If your plan still won't cover a specific drug you need, you can appeal. If you want to get the drug before your appeal is decided, you may have to pay out of pocket for the prescription. You may consider changing your Part D plan when permissible to one that does cover the specific prescription drug. Keep the receipt and give a copy of it to the person deciding your appeal. If you win the appeal, the plan will pay you back.

Medication Therapy Management (MTM)

A pharmacist or other health provider does a comprehensive review of all your medications and talks with you about

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you are taking
- Whether your costs can be lowered
- Other problems you are having

Medicare Prescription Drug Coverage

AD ASTRA

Plans with Medicare prescription drug coverage must offer additional Medication Therapy Management (MTM) services to members who meet certain requirements. Members who qualify can get MTM services to help them understand how to manage their medications and use them safely.

MTM services may vary in some plans. MTM services are free and usually include a discussion with a pharmacist or health care provider to review your medications.

The pharmacist or health care provider may talk with you about:

- How well your medications are working
- Whether your medications have side effects
- If there might be interactions between the drugs you are taking
- Whether your costs can be lowered
- Other problems you are having

For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf, Section 30.

Medication Therapy Management Conditions

To qualify for MTM services, you need to meet all of these conditions

- You have more than one chronic health condition
- You take several different medications
- Your medications have a combined cost of more than $4,044 per year

AD ASTRA

Medicare Prescription Drug Coverage

Your drug plan may enroll you in a medication therapy management (MTM) program if you meet all of these conditions:

- You have more than one chronic health condition (like hypertension; heart failure; diabetes; dyslipidemia; respiratory disease (like asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disorders; bone disease-arthritis (like osteoporosis, osteoarthritis, or rheumatoid arthritis); or a mental health condition (like depression, schizophrenia, bipolar disorder, or chronic and disabling disorders).
- You take several different medications.
- Your medications have a combined cost of more than $4,044 (for 2019) per year. This dollar amount (which can change each year) is estimated based on your out-of-pocket costs and the costs your plan pays for the medications each calendar year. Your plan can help you find out if you may reach this dollar limit.

These are the requirements to qualify for additional MTM services. They're NOT requirements to join the Medicare plan itself. Even if you don't qualify for the MTM services, you may still be eligible to enroll in the plan.

You can contact the plan directly to find out more about the plan's MTM services and what's required to get these services.

For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter7.pdf, Section 30.

NEW Elimination of Gag Clauses

- Know the Lowest Price Act of 2018
  - Prohibits Medicare drug plans from restricting or penalizing a pharmacy for disclosing price information to an enrollee
  - Allows pharmacies to disclose difference between the negotiated price and a lower price without using any health insurance coverage
  - CMS already instructed plans to eliminate gag clauses, but legal requirement applies to plan years beginning on or after January 1, 2020
  - Enrollees can choose to pay cash at the pharmacy and submit claim to plan for reimbursement and TrOOP counting

Medicare Prescription Drug Coverage

PD ASTRA

Gag clauses are provisions in contracts that insurance plans and their pharmacy benefit managers enter into with pharmacies. These clauses prevent pharmacists from telling customers when they could pay less for a drug by paying cash, instead of billing their insurance and paying the required copay or deductible. On May 17, 2018, CMS sent a letter to MA and Part D plans explaining that "gag clauses" that keep patients from knowing how to get the best deal are completely unacceptable, as part of the "American Patients First" initiative to lower prescription drug costs.

On October 10, 2018, the Know the Lowest Price Act of 2018 was signed into law. The law amends the Social Security Act by adding a prohibition on limiting certain information on drug prices. The law states that "a Medicare Prescription Drug Plan (PDP) and an MA organization shall ensure that each PDP or Medicare Advantage with Prescription Drug Coverage (MA-PD) offered by the plan or organization doesn't restrict a pharmacy that dispenses a prescription drug or biological from informing, nor penalize such pharmacy for informing, an enrollee in such plan of any differential between the negotiated price of, or copayment or coinsurance for, the drug or biological to the enrollee under the plan and a lower price the individual would pay for the drug or biological if the enrollee obtained the drug without using any health insurance coverage.'' Although, CMS already instructed the plans to eliminate the gag clauses, this law requirement applies to plan years beginning on or after January 1, 2020.

If you use your plan for every prescription, the plan can conduct proper safety checks and concurrent drug use reviews. You can ask your pharmacist if there's a less expensive option available. As a result of the Know the Lowest Price Act, your pharmacist can tell you if it's less expensive to pay for the drug out-of-pocket. You can also submit your receipts to your plan to have these costs counted to your yearly TrOOP balance. Check with your plan to find out how. For additional information about which claims may be reimbursable, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter-14-Coordination-of-Benefits-v09-17-2018.pdf.

Things to Consider Before Joining a Plan

- Important questions to ask
  - Do you have other current health insurance?
  - Is any prescription drug coverage you might have as good as (creditable) Medicare drug coverage?
  - How does your current coverage work with Medicare?
  - Could joining a plan affect your current coverage or family member's coverage?

AD ASTRA

Medicare Prescription Drug Coverage

There are several things to consider before joining a Medicare drug plan. When deciding if Medicare drug coverage is right for you, look at the type of health insurance you have currently and how that affects your choices.

If you have prescription drug coverage, you need to find out whether it's creditable prescription drug coverage. Your current insurer or plan provider must notify you each year whether your coverage is creditable prescription drug coverage. If you haven't heard from them, call them or your benefits administrator to find out. Also, you may want to consider keeping your creditable prescription drug coverage rather than choosing a Medicare drug plan. It's important to find out how Medicare coverage affects your current health insurance plan to be sure you don't lose doctor or hospital coverage for yourself or your family members.

If you have employer or union coverage, call your benefits administrator before you make any changes, or sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. Also, you may not be able to drop your employer or union drug coverage without also dropping your employer or union health (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents.

You can get information on how different types of current coverage work with Medicare prescription drug coverage by visiting Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Ways To Enroll

- Decide which plan is best for you and enroll
  - Online enrollment
    - Medicare.gov/find-a-plan
    - Plan's website
  - Enroll by phone
    - Call 1-800-MEDICARE (1-800-633-4227)
    - TTY: 1-877-486-2048
    - Call the plan
  - Mail or fax paper application to plan

Medicare Prescription Drug Coverage

AD ASTRA

After you pick a plan that meets your needs, call the company offering it, and ask how to enroll. You'll have to give the number on your Medicare card when you enroll.

You can enroll with the plan directly. All plans must offer paper enrollment applications. Also, plans may let you enroll through their website or over the phone. Most plans also participate and offer enrollment through Medicare's website at Medicare.gov/find-a-plan. You can also call Medicare to enroll at 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

- Plans must process applications in a timely manner, and after you apply, the plan must notify you that it has accepted or denied your application.
- It's a good idea to keep a copy of your application, confirmation number, any other papers you sign, and letters or materials you get.

You can find the steps and worksheets to help you with this process in "Your Guide to Medicare Prescription Drug Coverage," (CMS Product No. 11109) at Medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.

NOTE: There are a small number of plans that may have more limited enrollment options, including some Special Needs Plans (SNPs), Medicare Cost Plans, and consistently poor performing plans that have gotten less than a 3-star rating for 3 consecutive years. In these cases, you may not be able to enroll online. You can still call the plan directly to enroll.

What New Members Can Expect

- Your plan will send you
  - An enrollment letter
  - Membership materials, including card
  - Customer service contact information
- If your current drug isn't covered by plan
  - You can get a transition supply (generally 30 days)
  - Work with prescriber to find a drug that's covered
  - Request an exception if no acceptable alternative drug is on the list

Medicare Prescription Drug Coverage

AD ASTRA

When you join a plan, or when Medicare enrolls you in a plan, the plan will send you an enrollment letter and membership materials, including an identification card and customer service information with a toll-free phone number and website address.

Plans will also have a transition process in place for you if you're new to the plan and taking a drug that isn't on the plan's formulary. The plan must let you get a 30-day temporary supply of the prescription (a 90-day supply if you're a resident of a long-term care facility). This gives you time to work with your prescribing doctor to find a different drug that's on the plan's formulary. If an acceptable alternative drug isn't available, you or your doctor can request an exception from the plan, and you can appeal denied requests.

Annual Notice of Change (ANOC)

- All Medicare drug plans must send an ANOC to members to get no later than September 30
  - Evidence of Coverage (EOC) to be delivered by October 15
- Will include information for upcoming year
  - Summary of Benefits
  - Formulary
  - Changes to monthly premium and/or cost-sharing
- Read ANOC carefully and compare your plan with other plan options

Medicare Prescription Drug Coverage

AD ASTRA

Every year, Medicare drug plans are required to send an Annual Notice of Change (ANOC) to all plan members no later than September 30. The following materials may be sent with the ANOC: a summary of benefits, notification of availability of electronic materials, a provider directory, a pharmacy directory, an "opt-in" email option for future notices, and a copy of the formulary for the upcoming year. Read the ANOC carefully. The letter will explain any changes to your current plan, including changes to the monthly premium and changes to cost-sharing information like copayments or coinsurance.

Plans must send an Evidence of Coverage (EOC) to all members by October 15 each year. It gives details about the plan's service area, benefits, and formulary; how to get information, benefits, and Extra Help; and how to file an appeal.

NOTE: Starting in 2019, the ANOC must be delivered by September 30, 15 days before the start of the annual Open Enrollment Period (OEP) (October 15), and enrollees must get it before the EOC. The Medicare Advantage (MA) and Part D EOC must be delivered on October 15 (the 1st day of the OEP), rather than 15 days prior to that date.

For more information on Centers for Medicare and Medicaid Services (CMS) contract year 2019 policy changes and updates, visit CMS.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02.html.

Extra Help With Part D Drug Costs

- What's Extra Help?
- How to qualify
- Enrollment
- Continuing eligibility

Medicare Prescription Drug Coverage

AD ASTRA

Extra Help With Part D Drug Costs covers:

- What's Extra Help?
- How to qualify (income and resource limits)
- Enrollment
- Continuing eligibility

What Is Extra Help?

- Program to help people pay for Medicare Part D prescription drug costs
  - Also called the low-income subsidy (LIS)
- For people with limited income and resources
  - Lowest income and resources
    - Pay no premiums or deductible and small or no copayments
  - Slightly higher income and resources
    - Pay a reduced deductible and a little more out-of-pocket
- You won't enter the coverage gap or pay late enrollment penalty if you qualify
- If you reach catastrophic coverage limit ($5,100) and have Extra Help, you'll generally pay nothing for covered drugs for the rest of the year
- Special Enrollment Period (SEP)
  - ➢ Changed in 2019 - Once per calendar quarter during first 9 months each year

Medicare Prescription Drug Coverage

Extra Help is also known as the low-income subsidy (LIS). Getting "Extra Help" means Medicare helps pay your Medicare prescription drug coverage monthly premium, any yearly deductible, coinsurance, and copayments. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs.

If you have the lowest income and resources, you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out-of-pocket.

If you qualify for Extra Help, you won't enter the coverage gap or pay a late enrollment penalty. Also, if you get Extra Help and reach the catastrophic coverage limit ($5,100 in 2019), you generally will pay nothing for covered drugs for the rest of the year. You'll also have a Special Enrollment Period (SEP) to switch plans once per calendar quarter during the first 9 months each year, with the new plan going into effect the first day of the next month.

NOTE: Residents of U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.

2020 Extra Help
Income and Resource Limits

- Income limits
  - Below 150% of the federal poverty level
    - $19,140* per year for an individual, or $25,860* per year for a married couple
  - Based on family size
- Resources limits
  - Up to $14,800* per year for an individual, or $29,160* per year for a married couple
    - Doesn't include $1,500/person for funeral or burial expenses
    - Counts savings and investments
    - Real estate (except your home)

*Higher amounts for Alaska and Hawaii

Medicare Prescription Drug Coverage

AD ASTRA

You may get Extra Help if you have Medicare, income below 150% of the federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the limits shown on the slide for 2020. If you're married and live with your spouse, both of your incomes and resources count, even if only one of you applies for Extra Help. If you're married and don't live with your spouse when you apply, only your income and resources count. The income is compared to the FPL for a single person or a married person, as appropriate. Whether you and/or your spouse have dependent relatives who live with you and who rely on you for at least half of their support is also taken into consideration. This means that a grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Only 2 types of resources are used to see if you're eligible for Extra Help:

- Liquid resources (like savings accounts, stocks, bonds, and other assets that can be changed into cash within 20 days)
- Real estate, not including your home or the land on which your home is located

Items like wedding rings and family heirlooms aren't counted when seeing if you qualify for Extra Help.

NOTE: The income and resource levels listed are for 2020 and can go up each year. Income levels are higher if you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or if you work. Updated resource limits are usually released each fall for the next calendar year. Updated income limits are usually released each February for the same calendar year.

Qualifying for Extra Help

- You automatically qualify for Extra Help if you get
  - Full Medicaid coverage
  - Supplemental Security Income
  - Help from Medicaid paying your Part B premium (Medicare Savings Program)
- All others must apply
  - Online at ssa.gov/medicare/prescriptionhelp/
  - Call Social Security (SSA) at 1-800-772-1213
  - TTY: 1-800-325-0778
    - Ask for "Application for Help With Medicare Prescription Drug Plan Costs" (SSA-1020)
  - Contact your state Medicaid agency

Medicare Prescription Drug Coverage

AD ASTRA

You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income benefits, or help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program (MSP)).

If you don't meet one of these conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your state Medicaid agency.

You can apply for Extra Help by

- Applying online at ssa.gov/medicare/prescriptionhelp/.
- Completing a paper application you can get by calling Social Security at 1-800-772-1213. TTY: 1-800-325-0778.
- Applying through your state Medicaid agency.
- Working with a local organization, like a State Health Insurance Assistance Program.

You can apply on your own behalf, or someone with the authority to act on your behalf can file your application (like with Power of Attorney), or you can ask someone else to help you apply.

If you apply for Extra Help, Social Security will transmit the data from your application to your state Medicaid agency to also initiate an application for MSP, which can help you pay for your Medicare premiums.

Automatic and Facilitated Enrollment

People With Medicare and…	Basis for Qualifying	Data Source	Enrollment
Full Medicaid benefits	Automatically qualify	State Medicaid agency	Automatic enrollment in Part D drug plan (unless already in a drug plan) ▪ Letter on YELLOW paper ▪ Coverage starts first month eligible for Medicare and Medicaid ▪ Continuous Special Enrollment Period (SEP)
Medicare Savings Program	Automatically qualify	State Medicaid agency	Facilitated enrollment in Part D drug plan ▪ Letter on GREEN paper ▪ Coverage starts 2 months after CMS receives notice of your eligibility ▪ Continuous SEP
Supplemental Security Income benefits	Automatically qualify	Social Security (SSA)	
Limited income and resources	Must apply and qualify	SSA (most) or state Medicaid agency	

Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (CMS) uses state Medicaid data to identify people with Medicare who have full Medicaid benefits and people who get help from their state Medicaid Program paying their Medicare premiums (in a Medicare Savings Program). CMS uses data from Social Security (SSA) to identify people who have Medicare and are entitled to Supplemental Security Income but not Medicaid, or who have applied and qualified for Extra Help.

When you first qualify for Extra Help, CMS will enroll you in a Medicare drug plan if you don't join a plan on your own to be sure you have coverage. This applies whether you qualify automatically or whether you apply and qualify for Extra Help.

Each month, CMS identifies and processes new automatic and facilitated enrollments. CMS chooses plans randomly from those with premiums at or below the regional low-income premium subsidy amount so that you won't pay a premium if you qualify for full Extra Help. If you qualify for partial Extra Help, you'll pay a reduced premium or no premium.

If you have Medicare and full Medicaid benefits and don't choose and join a Medicare drug plan on your own, CMS will automatically enroll you in a plan that goes into effect the first day you have both Medicare and Medicaid. You'll get a yellow auto-enrollment notice with the name of the plan you're assigned to.

Other people who qualify for Extra Help will be assisted into a Medicare drug plan. The facilitated enrollment goes into effect 2 months after CMS gets notice that you're eligible. You'll get a facilitated enrollment letter on green paper, in one of 2 versions, full or partial Extra Help (described on slide 55).

NOTE: For more information and a complete guide to mailings from CMS, SSA, and plans, visit CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf.

2020 Extra Help Copayments

Extra Help Copayments	2020 Generic/Brand-name
Institutionalized (Level 3)	$0
Receiving Home and Community-Based Services (under waiver only) (Level 3)	$0
Up to or at 100% Federal Poverty Level (Level 2)	$1.30/$3.90
Full Extra Help (Level 1)	$3.60/$8.90
Partial Extra Help (Deductible/Cost-Sharing) (Level 4)	$89.00/15%

Medicare Prescription Drug Coverage

Copayment amounts vary if you qualify for Extra Help depending on the following:

- If you're living in an institution (like a nursing home) you don't pay a copayment
- If you're receiving Home and Community-Based Services you don't pay a copayment
- If your income is up to or at 100% of the Federal Poverty Level (FPL) you pay $1.30 for a generic drug (or brand-name drug treated as a generic), or $3.90 for brand-name covered prescriptions
- If your income is between 100% and 135% of the FPL, you pay either $3.60 for a generic drug (or brand-name drug treated as a generic), or $8.90 for brand-name covered prescriptions
- If you get Partial Extra Help, you pay a $89 deductible in 2020 and you pay 15% for each covered drug

Medicare's Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare's Limited Income NET Program
  - Has an open formulary
  - Doesn't require prior authorization
  - Includes standard safety and abuse edits to protect you from refilling too soon or therapy duplication
  - Has no network pharmacy restrictions
- Continuing Education credit webinars available
  - Run by Humana

Medicare Prescription Drug Coverage

AD ASTRA

Medicare's Limited Income Newly Eligible Transition (NET) program is designed to remove gaps in coverage for low-income individuals moving to Medicare prescription drug coverage.

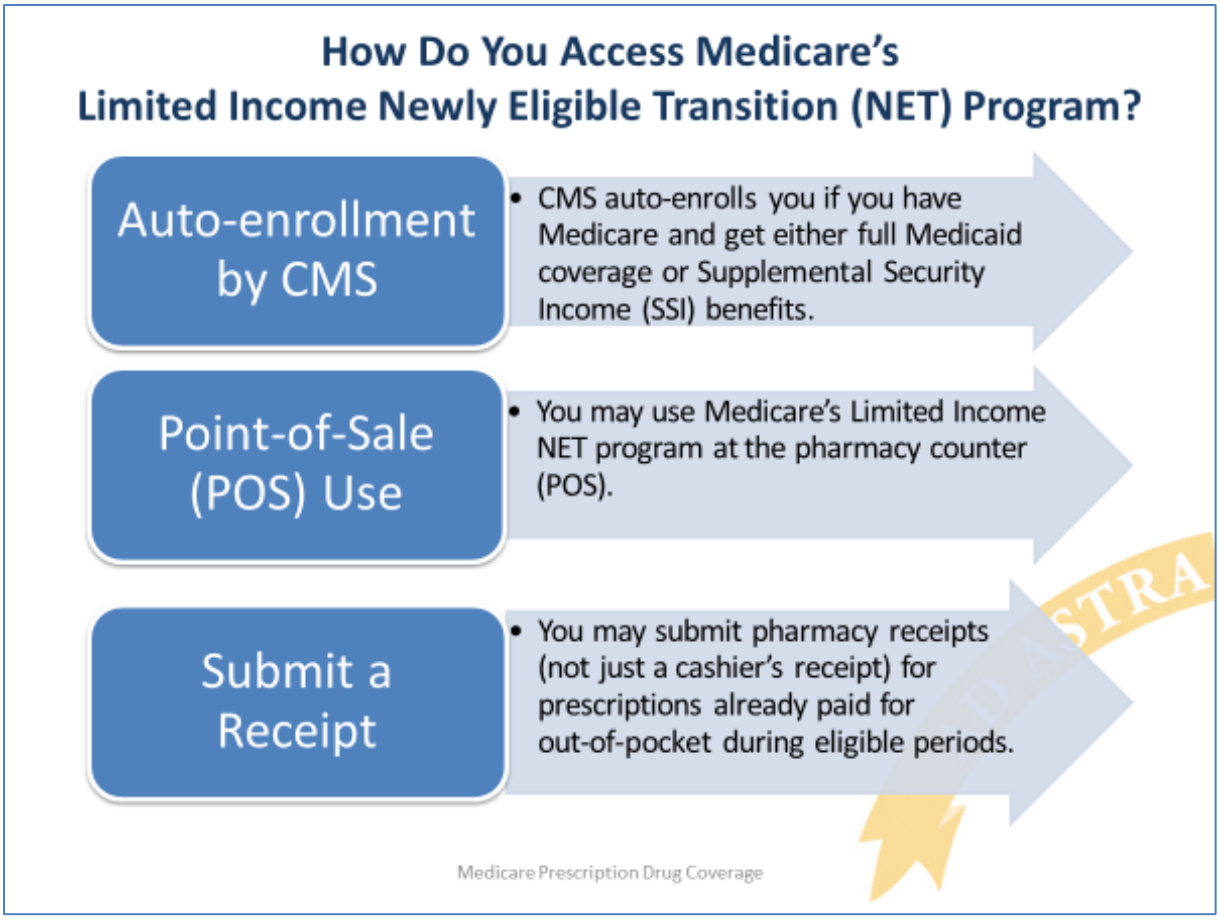
Enrollment in Medicare's Limited Income NET program is temporary and ends once a low-income person with Medicare gets coverage through a Medicare drug plan. The program gives point-of-sale coverage to people with Extra Help who don't yet have a Medicare drug plan. It also gives retroactive coverage to people who have full Medicaid coverage or get Supplemental Security Income benefits.

The Limited Income NET program has an open formulary (Part D covered drugs), doesn't require prior authorization, includes standard safety and abuse edits (like "refill too soon, or "therapy duplication"), and has no network pharmacy restrictions. However, CMS can't require a pharmacy to use this program.

To be eligible to use Medicare's Limited Income NET program, you must meet certain criteria:

- Have a valid Medicare Number, which is on your Medicare card
- Be eligible for Medicare Part D
- Not be enrolled in a Part D plan
- Not be enrolled in a retiree drug subsidy plan
- Not be enrolled in a Part C plan that doesn't allow associated enrollment in a Part D plan
- Haven't opted out of auto-enrollment
- Have a permanent address in the 50 states or the District of Columbia

The Limited Income Newly Eligible Transition (NET) Outreach Team is run by Humana, Inc. It provides live webinar training to State Health Insurance Assistance Program counselors and pharmacy providers. To schedule a webinar or for more information, email linetoutreach@humana.com. Visit humana.com/pharmacy/pharmacists/linet for more information and supporting documents like the Limited Income NET brochure and 4 Steps for Pharmacists.



There are 3 ways you can access Medicare's Limited Income Newly Eligible Transition (NET) program:

- **Auto-enrollment by the Centers for Medicare & Medicaid Services (CMS).** CMS auto-enrolls you in this program if you have Medicare and get either full Medicaid coverage or Supplemental Security Income (SSI) benefits. You're not automatically enrolled if you get help from your state Medicaid agency paying your Medicare Part B premiums (in a Medicare Savings Program (MSP)) or have applied and qualified for Extra Help. If you're auto-enrolled by CMS, your Medicare's Limited Income NET program coverage starts when you first have Medicare and get either full Medicaid coverage or SSI benefits, or during the last uncovered month—whichever is later.
- **Point-of-Sale (POS) Use.** If you get Extra Help, you may use Medicare's Limited Income NET program at the pharmacy counter (POS). Pharmacies aren't required to participate in the NET program.
- **Submit a receipt.** You may submit pharmacy receipts (not just a cashier's receipt) for prescriptions already paid for out of pocket during eligible periods to the Medicare Limited Income NET Program, P.O. Box 14310, Lexington, KY 40512-4310.

If you use Medicare's Limited Income NET program by POS (at the pharmacy counter) or by submitting a pharmacy receipt, you may

- Get retroactive coverage up to 36 months if you have Medicare and get either full Medicaid coverage or SSI benefits (or as far back as January 1, 2006, if your Medicaid determination goes back to that point in time)
- Get up to 30 days of current coverage if you get help from your state Medicaid agency paying for your Medicare Part B premiums (in an MSP) or have applied and qualified for Extra Help
- Get immediate coverage if you show evidence of Medicaid (like a Medicaid ID card or a copy of a current Medicaid award letter with effective dates) or Extra Help eligibility to the pharmacy at POS, even if CMS's systems can't confirm your eligibility status

Reassignment Notices

- People reassigned notified by CMS early November (BLUE paper)
  - Three versions of notice
    - People whose plans are leaving the Medicare Program
      - CMS product No. 11208 (MA Plan with prescription drug coverage)
      - CMS product No. 11443 (Medicare Advantage)
    - People whose premiums are increasing
      - CMS product No. 11209

Medicare Prescription Drug Coverage

AD ASTRA

In the fall, CMS reassigns certain people who qualify for Extra Help into new Medicare Prescription Drug Plans (PDPs) to make sure they continue to pay $0 premium for their drug coverage. CMS will reassign people who get Extra Help if their Medicare drug plan or Medicare health plan is leaving the Medicare Program as of December 31. These people will be reassigned into a new Medicare PDP regardless of whether they joined their current plan on their own, or Medicare enrolled them in a plan. People affected by reassignment will get a notice on BLUE paper in the mail from CMS by early November. There are 3 versions of the notice. Two versions are for people whose plans are leaving the Medicare Program:

- CMS Product No. 11208—informs people who qualify for Extra Help and whose Medicare PDP is leaving the Medicare Program that they'll be reassigned to a new PDP if they don't join a Medicare drug plan on their own by December 31.
- CMS Product No. 11443—informs people who qualify for Extra Help and whose Medicare Advantage (MA) Plan is leaving the Medicare Program that they'll be enrolled in a Medicare PDP if they don't join a new Medicare Advantage Plan or Medicare drug plan on their own by December 31.

A third version of the notice is for people whose premiums are increasing above the regional LIS premium subsidy amount (CMS Product No. 11209). It tells people which plan they'll be reassigned to, explains how to stay in their current Medicare drug plan if it's still available, and lets them know how to join a new plan. The notice also includes a list of plans in the region available for $0 premium and plans' phone numbers. If people who get a notice don't tell their current plan that they want to stay or join a new plan on their own by December 31, 2019, Medicare will reassign them into a new plan with coverage effective January 1, 2020.

NOTE: Visit CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11221-P.pdf to download the tip sheet, "Information Partners Can Use on: Reassignment" (CMS Product No. 11221-P) and CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf to download the "Guide to Consumer Mailings."

Changes in Qualifying for Extra Help

Medicare reestablishes eligibility each fall for next year

- If you no longer automatically qualify
  - Medicare sends "Loss-of-Deemed-Status" notice in September (GRAY paper)
    - Includes Social Security application to reapply
- If your status changes and you again automatically qualify
  - Medicare sends "Deemed Status" notice (PURPLE paper)
- If you automatically qualify, but your copayment changed
  - Medicare sends "Change in Extra Help Co-payment" notice in early October (ORANGE paper)

Medicare Prescription Drug Coverage

AD ASTRA

Every August, Medicare reestablishes Extra Help eligibility for the next calendar year if you automatically qualify. Your Extra Help continues or changes depending on whether you're still eligible for full Medicaid coverage, get help from Medicaid paying Medicare premiums, or get Supplemental Security Income (SSI). Any changes go into effect the following January.

If you were automatically eligible in a year, then you continue to qualify for Extra Help through December of that year. If you become no longer eligible, your automatic status ends on December 31 of that year. If you no longer automatically qualify for Extra Help, you'll get a letter from Medicare on gray paper with an Extra Help application from Social Security.

When people who no longer automatically qualify regain their eligibility for full Medicaid coverage, a Medicare Savings Program, or SSI, Medicare mails them a new letter on purple paper informing them that they now automatically qualify for Extra Help.

Also, you may continue to qualify automatically for Extra Help, but your copayment level may change due to a change from one of the following categories to another: you're institutionalized with Medicare and Medicaid, you have Medicare and full Medicaid coverage, you get help from Medicaid paying Medicare premiums (belong to a Medicare Savings Program), or you get SSI benefits but not Medicaid. In those cases, you'll get a letter from Medicare on orange paper telling you about the change in your copayment level for the next year.

Redetermination Process

- People who applied and qualified for Extra Help
  - Four types of redetermination processes
    - Initial
    - Cyclical or recurring
    - Subsidy-changing event (SCE)
    - Other event (change other than SCE)

AD ASTRA

There are 4 types of redetermination processes for people with Extra Help:

1. Initial redeterminations – To redetermine eligibility, Social Security (SSA) selects a group of people who are eligible for Extra Help, but their eligibility may have changed due to a change in circumstances. These people get a redetermination form in the mail in September. They must complete and return the form within 30 days, even if nothing has changed, or SSA may end their eligibility for Extra Help, starting January 1 of the next year.
2. Cyclical or recurring redeterminations – Each year, SSA also selects a random group of people with Extra Help to redetermine their eligibility for the following year. These people get a redetermination form in the mail in September. They must complete and return the form within 30 days of receiving it, even if nothing has changed, or SSA may end their eligibility for Extra Help, starting January 1 of the next year.
3. Subsidy-changing event (SCE) – People with Extra Help may experience events that can change how much Extra Help they can still get, like marriage, divorce, separation, annulment, or the death of a spouse. They're required to report these events to SSA and complete and return the SCE redetermination form or they may lose their eligibility for Extra Help. Any change will take effect as of the first day of the month following the month of initial report of change.
4. Other events – Eligibility for Extra Help may also be redetermined by SSA based on other changes, besides SCEs, like a recent decrease in income due to a cut in work hours.

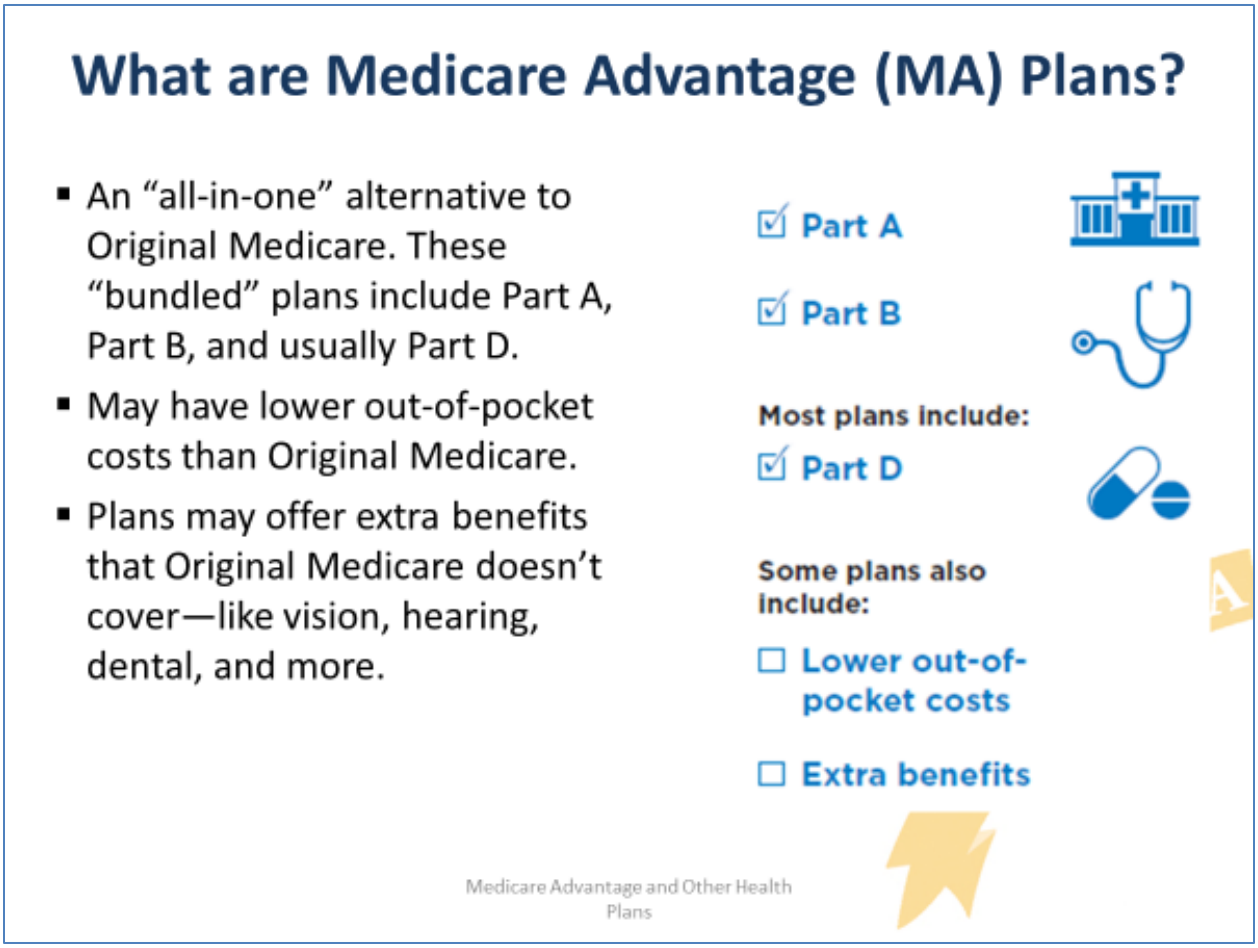
Medicare Advantage Plans

- Health plans run by private companies that provide Part A and Part B benefits
  - Part of the Medicare Program
  - Approved by Medicare
  - Most plans include prescription drug coverage—Part D
  - May provide vision and dental services
- Sometimes called Part C
- Available across the country

Medicare Advantage and Other Health Plans

AD ASTRA

- Medicare Advantage (MA) Plans are health plan options approved by Medicare and run by Medicare-approved private companies. In MA Plans, you get all Medicare-covered Part A (Hospital Insurance) and Part B (Medical Insurance) services through that plan.
- Many MA plans also include Medicare prescription drug coverage. This is called Medicare Part D coverage. This called an MA-PD plan. MA plans which do not cover Part D benefits are called MA-only plans.
- MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, like vision or dental services. The plan may have special rules that its members need to follow.
- MA Plans are part of the Medicare Program and are sometimes called Part C.
- MA Plans are offered in many areas of the country by Medicare-approved private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.



Medicare Advantage (MA) is an "all-in-one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.

Some plans may have lower out-of-pocket costs than Original Medicare. Some plans offer extra benefits that Original Medicare doesn't cover—like vision, hearing, or dental.

If you have an MA Plan, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. If you're not planning to leave your MA Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.

MA Plans can vary in benefits and costs. Read individual plan materials carefully to make sure that you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered, and how much it costs.

How do Medicare Advantage Plans work?

- In an MA Plan you
  - Are still in Medicare with all rights and protections
  - Still get those services covered by Part A and Part B but the MA Plan covers those services
  - May choose a plan that includes prescription drug coverage
  - Can be charged different out-of-pocket costs
  - Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility (SNF) care
  - May choose a plan with extra benefits like vision, dental or fitness and wellness benefits
  - Have a yearly limit on your out-of-pocket costs

Medicare Advantage and Other Health Plans

AD ASTRA

- In an MA Plan you
- Are still in Medicare with all rights and protections
- Still get those services covered by Part A and Part B, but the MA Plan covers those services instead of Original Medicare (must have both Part A and Part B to join an MA Plan)
- May choose a plan that includes prescription drug coverage
- Can be charged different out-of-pocket costs
- Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility (SNF) care
- May choose a plan that includes extra benefits like vision, dental, or fitness and wellness benefits offered at the plan's expense (not covered by Medicare)
- Have a yearly limit on your out-of-pocket costs

Medicare Advantage Plan Costs

- Your out-of-pocket costs in an MA Plan vary depending on
  - If the plan charges a monthly premium
    - You pay the plan's monthly premium (if any) in addition to the regular Medicare Part B premium— $144.60 in 2020
  - If the plan pays any of your monthly Medicare premium
    - Some MA Plans will help pay all or part of your Part B premium (sometimes called a "Medicare Part B premium reduction")
  - Whether the plan has a yearly deductible or any additional deductibles for certain services
  - How much you pay for each visit or service (copayments or coinsurance)

Medicare Advantage and Other Health Plans

AD ASTRA

Your out-of-pocket costs in an MA Plan vary depending on

- Whether the plan charges a monthly premium. You pay this in addition to the Medicare Part B premium. The standard monthly Part B premium in 2020 is $144.60. You may pay more depending on your income from 2 years ago.
- Whether the plan pays any of your monthly Medicare premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This benefit is sometimes called a "Medicare Part B premium reduction."
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much you pay for each visit or service (copayments or coinsurance). For example, the plan may charge a copayment, like $10 or $20 every time you see a doctor.

Medicare Advantage (MA) Plan Costs (continued)

- Your out-of-pocket costs in an MA Plan vary depending on (continued)
  - The type of health care services you need and how often you get them
  - Whether you get services from a provider in the plan's network
  - Whether you go to a doctor or supplier who accepts assignment
  - Whether the plan offers extra benefits that require an extra premium
  - The plan's yearly limit on your out-of-pocket costs for all medical services
    - Once you reach this limit, you'll pay nothing for covered services
  - Whether you have Medicaid or get help from your state with health care costs.

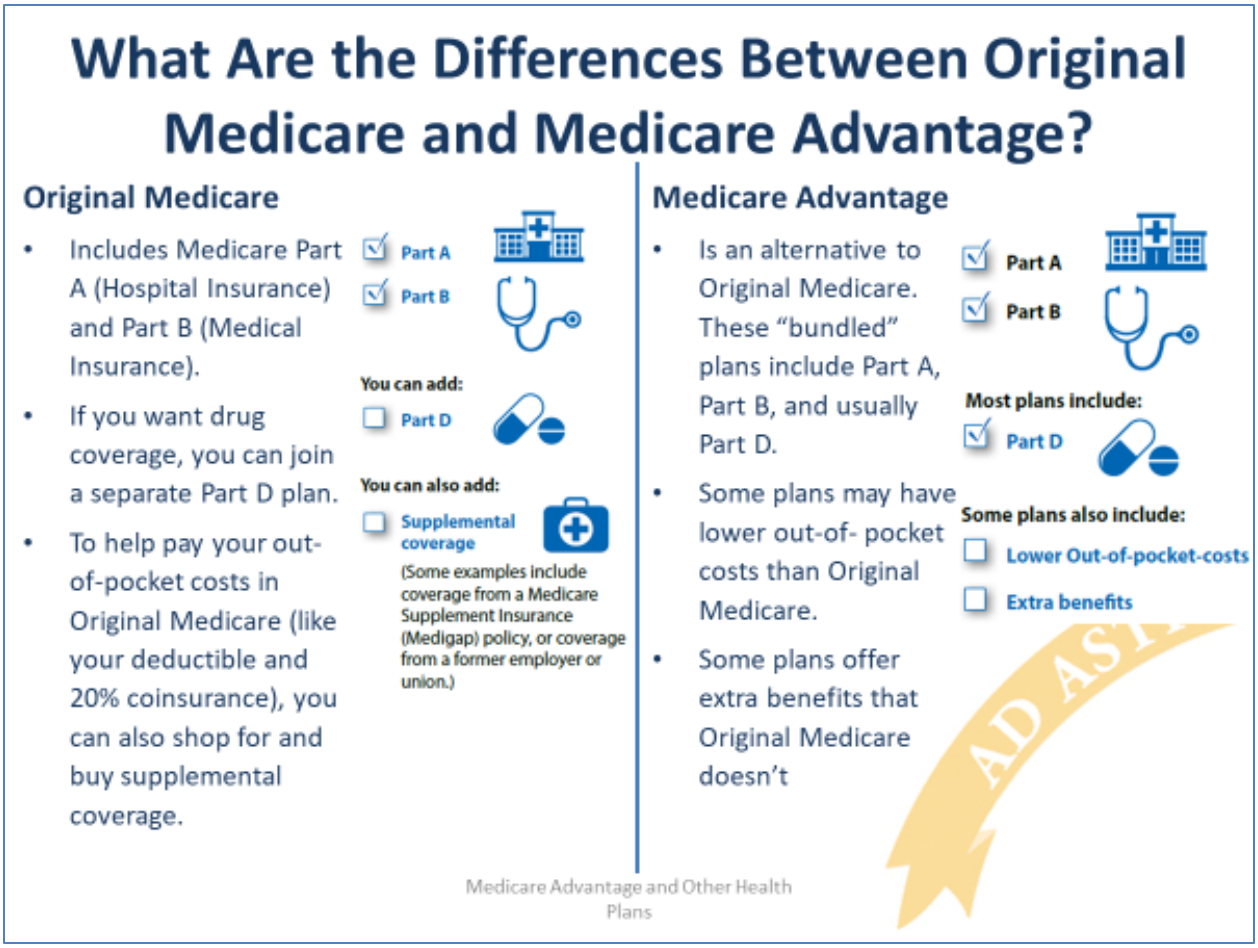
Medicare Advantage and Other Health Plans

AD ASTRA

Your out-of-pocket costs in an MA Plan vary depending on (continued)

- The type of health care services you need and how often you get them.
- Whether you get services from a provider in the plan's network.
- Whether you go to a doctor or supplier who accepts assignment. Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.
- Whether the plan offers extra benefits that require an extra premium.
- The plan's yearly limit on your out-of-pocket costs for all medical services. Once you reach this limit, you'll pay nothing for covered services.
- Whether you have Medicaid or get help from your state with health care costs.

Each year, plans set the amounts they charge for premiums, deductibles, and services. The plan (rather than Medicare) decides how much you pay for the covered services you get. What you pay the plan may change only once a year, on January 1.



When you first enroll in Medicare and during certain times of the year, you can choose how to get your Medicare coverage.

There are 2 main ways to get Medicare:

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). If you want drug coverage, you can join a separate Part D plan. To help pay your out-of-pocket costs in Original Medicare (like your deductible and 20% coinsurance), you can also shop for and buy supplemental coverage.

- Medicare Advantage is an alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D. Some plans may have lower out-of-pocket costs than Original Medicare, and some plans offer extra benefits that Original Medicare doesn't.

NEW Expanded Health Related Extra Benefits

- Calendar year 2019, the Centers for Medicare & Medicaid Services (CMS) expanded definition of "primarily health related" to consider an item or service as primarily health related if it is used to
  - Diagnose
  - Compensate for physical impairments
  - Improve the functional/psychological impact of injuries or health conditions
  - Reduce avoidable emergency and health care use
- Benefit must focus on enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not provided by one

Medicare Advantage and Other Health Plans

ADASTRA

Beginning in calendar year 2019, the Centers for Medicare & Medicaid Services (CMS) expanded the definition of "primarily health related" to consider an item or service as primarily health related if it's used to diagnose, compensate for physical impairments, acts to ameliorate (improve) the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and health care utilization. A supplemental benefit is **not** primarily health related under the previous or new definition if it's an item or service that's solely or primarily used for cosmetic, comfort, general use, or social determinant purposes.

For CMS to approve a supplemental benefit, the benefit must focus directly on an enrollee's health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one.

NOTE: CMS calls these "Extra benefits" rather than "Supplemental benefits" in consumer materials, to clearly distinguish from supplement insurance (Medigap).

Expanded Coverage in Medicare Advantage Plans - 2020

- In 2020, chronically ill patients with Medicare Advantage have the possibility of accessing a broader range of supplemental benefits that are not necessarily health-related but have a reasonable expectation of improving or maintaining the health or overall function of the enrollees.
- These benefits can address social determinants of health for beneficiaries with chronic disease.
  - For example, beneficiaries enrolled in a Medicare Advantage plan could now receive meal delivery in more circumstances, transportation for non-medical needs like grocery shopping, and home environment services in order to improve their health or overall function as it relates to their chronic illness.

Medicare Advantage and Other Health Plans

AD ASTRA

Such supplemental benefits could include things that are not normally thought of as "health care," like, for example, groceries, air conditioners for beneficiaries with asthma, and even provider organized Lyft and Uber rides to and from and medical appointments.

Previously, MA supplemental benefits had to have a primary purpose of preventing, curing, or diminishing an illness. This ruled out those that might affect health outside the traditional health system, like groceries and non-ambulance transportation. CMS's new regulation will permit such nontraditional MA benefits so long as they "increase health and improve quality of life."

Examples also include

For a patient with asthma, for example, a Medicare Advantage plan could cover home air cleaners and carpet shampooing to reduce irritants that may trigger asthma attacks.

For someone with heart disease, a plan could provide heart healthy food or produce.

And for someone with diabetes, a plan could provide transportation to a doctor's appointment, diabetes education program or to see a nutritionist.

Who Can Join a Medicare Advantage Plan?

- To be eligible, you must
  - Be enrolled in Medicare Part A (Hospital Insurance)
  - Be enrolled in Medicare Part B (Medical Insurance)
  - Live in the plan's service area
  - Be a United States (U.S.) citizen or lawfully present in the U.S.
  - Not be incarcerated
- To join you must also
  - Provide necessary information to the plan
  - Follow the plan's rules
  - Only belong to one plan at a time

Medicare Advantage and Other Health Plans

AD ASTRA

- Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join an MA Plan, you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area. You must be a United States (U.S.) citizen or lawfully present in the U.S., and you can't be incarcerated.
- To join an MA Plan, you must also agree to
  - Provide the necessary information to the plan, like your Medicare number, address, date of birth, and other important information
  - Follow the plan's rules
  - Belong to one MA Plan at a time

To find out which MA Plans are available in your area, visit Medicare.gov/find-a-plan/questions/home.aspx or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Medicare Advantage (MA) Plans and End-Stage Renal Disease (ESRD)

- Usually you can't enroll if you have ESRD
- There are limited exceptions
  - Transition from one plan to another within the same parent organization
  - No break between coverage
  - Must meet all other enrollment requirements
  - If you joined the plan without ESRD, but developed ESRD while in the plan, you may stay in the plan
- If you've had a successful kidney transplant or no longer require a regular course of dialysis
  - You aren't considered to have ESRD for MA eligibility purposes
- Starting in 2021, people with ESRD will be able to join MA Plans without restriction

Medicare Advantage and Other Health Plans

AD ASTRA

People with End-Stage Renal Disease (ESRD) usually can't join an MA Plan or other Medicare health plan. However, there are some exceptions. An individual with ESRD enrolled in employer-sponsored coverage, whether MA or commercial (like, non-Medicare), can enroll in another plan, if the plan is part of the same parent organization and meets the criteria for doing so. For example, an individual who develops ESRD while enrolled in a group health plan (like, from an employer) may be allowed to enroll in an MA Plan offered by the same plan parent organization, if there's no break between coverage. People with Medicare with ESRD who are already enrolled in an MA Plan may also enroll in another MA Plan within the same parent organization as long as:

- The new MA Plan operates in the same state
- The person with Medicare meets all the other requirements for enrollment in that MA Plan (as in the previous MA Plan)

CMS will permit a change from an HMO to a PPO or a PFFS Plan within the same parent organization, as long as the change meets all of the criteria. The term "parent organization" is defined as an entity that owns one or more contracts (H numbers) with CMS to provide MA Plans.

A person who has had a successful kidney transplant or no longer requires a regular course of dialysis treatment isn't considered to have ESRD for purposes of MA eligibility.

NOTE: Starting in 2021, people with ESRD will be able to join MA Plans without restriction.

When You Can Join Medicare Advantage (MA) Plans

Initial Enrollment Period	▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65 **Important:** If you delay Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted.
Medicare due to a disability	▪ 7-month period begins 3 months before the 25th month of disability benefits ▪ Ends 3 months after the 25th month of disability benefits

Medicare Advantage and Other Health Plans

You can join a Medicare Advantage (MA) Plan during your Initial Enrollment Period, which is a 7-month period that begins 3 months immediately before [your first entitlement to both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)] the month you turn 65; includes the month you turn 65; and, ends 3 months after the month you turn 65.

Important: If you delay Medicare Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted. Your chance to join lasts for 2 full months after the month your employer group coverage ends. For more information, see the Medicare Managed Care Manual, Chapter 2, at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf and visit Medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/esrd-and-medicare-advantage-plans.html.

If you get Medicare due to a disability, you can join during the 7-month period that begins 3 months before your 25th month of getting Social Security or Railroad Retirement disability benefits, and ends 3 months after your 25th month of disability benefits.

When You Can Join or Switch Medicare Advantage (MA) Plans

Medicare Open Enrollment Period "open enrollment"	▪ October 15—December 7 ▪ Coverage begins January 1

*You can only join one MA Plan at a time, and enrollment is generally for a calendar year.
*Plans must be allowing new members to join

AD ASTRA

Medicare Advantage and Other Health Plans

You can also join or switch to another Medicare Advantage (MA) Plan during the Medicare Open Enrollment Period (OEP), or "open enrollment."

Open enrollment runs from October 15 through December 7 each year and anyone with Medicare can join, switch, or drop an MA Plan during this time. Your coverage will begin on January 1, if the plan gets your request by December 7.

You can only join one MA Plan at a time, and enrollment in a plan is generally for a calendar year.

Plans must be allowing new members to join. Plans may be prohibited from accepting new members if there's a Centers for Medicare & Medicaid Services (CMS)-approved capacity limit, or a CMS-issued enrollment sanction in effect.

When You Can Join or Switch Medicare Advantage (MA) Plans (continued)

Special Enrollment Period (SEP)	▪ You move out of your plan's service area ▪ You have Medicaid and Medicare ▪ Your plan leaves the Medicare Program or reduces its service area ▪ You leave or lose employer or union coverage ▪ You enter, live at, or leave a long-term care facility (like a nursing home) ▪ You have an SEP to changes plans once each quarter for the first three quarters of the year, if you qualify for Extra Help ▪ You lose your Extra Help status ▪ You're sent a retroactive notice of Medicare entitlement ▪ Other exceptional circumstances

Medicare Advantage and Other Health Plans

You may be able to join or switch plans outside of open enrollment if any of these special circumstances that grant a Special Enrollment Period (SEP) apply to you:

- You move out of your plan's service area.
- You have Medicaid and Medicare.
- You're enrolled in a plan that decides to leave the Medicare Program or reduce its service area.
- You leave or lose employer or union coverage.
- You enter, live at, or are leaving a long-term care facility (like a nursing home). Your chance to join, switch, or drop coverage lasts as long as you live in the institution and for 2 full months after the month you leave the institution.
- You also have a Special Enrollment Period and can switch plans once each quarter for the first three quarters of the year, with the new plan going into effect the first day of the next month.
- You receive notice of retroactive Medicare entitlement.
- Other exceptional circumstances.

When You Can Join or Switch MA Plans

5-Star Special Enrollment Period (SEP)	▪ Can switch to 5-Star Medicare Advantage (MA), Prescription Drug Plan (PDP), MA Plan with prescription drug coverage (MA-PD), or Cost Plan ▪ Enroll once per year from December 8 – November 30 ▪ New plan starts first day of month after enrolled ▪ Star ratings given once per year • Ratings assigned in October and effective January 1 • Use Medicare Plan Finder to see star ratings ▫ Look at Overall Star Rating to find eligible plans

Caution: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You'll have to wait until the next applicable enrollment period to get coverage and may have to pay a penalty.

Medicare Advantage and Other Health Plans

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-Star rating is considered excellent.

- You can use the 5-Star Special Enrollment Period (SEP) to enroll in a 5-Star Medicare Advantage (MA)–only Plan, a 5-Star MA Plan with prescription drug coverage (MA-PD), a 5-Star Medicare Prescription Drug Plan (PDP), or a 5-Star Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're currently enrolled in a plan with a 5-Star overall rating, you may use this SEP to switch to a different plan with a 5-Star overall rating.
- The Centers for Medicare & Medicaid Services (CMS) also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-Star plans without drug coverage choose a prescription drug plan, if that combination is allowed under CMS rules.
- You may use the 5-Star SEP to change plans one time between December 8 and November 30. Once you enroll in a 5-Star plan, your SEP ends for that year and you're only allowed to make other changes during open enrollment periods. Your enrollment will start the first day of the month after the month the plan gets your enrollment request.

Plans get their star ratings in October each year. Although CMS assigns the plan star ratings in October, plans won't post their star rating until January 1. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan/questions/home.aspx. Look for the Overall Star Rating to identify 5-Star plans that you can change to during this SEP. The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You'll have to wait until the next open enrollment period to get coverage and may have to pay a penalty.

Low Performing Plan

- Low performing star rating status
  - You may have a one-time option to switch to another Medicare drug plan or Medicare Advantage plan with a rating of 3, 4, or 5 stars if your plan's summary rating was less than 3 stars for 3 years
  - Low Performance Icon (LPI) appears on Plan Finder
  - Plans can't attempt to discredit their LPI status by showcasing a separate higher rating

Medicare Advantage and Other Health Plans

AD ASTRA

A contract that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years gives these members a one-time option to switch to another Medicare drug plan with 3 stars or better. Visit CMS.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/Downloads/October-11627-combined.pdf for more information.

The summary rating scores the drug plan's quality and performance in many different topics that fall into 4 categories:

1. **Drug plan customer service**: Includes how well the plan handles member appeals.
2. **Member complaints and changes in the drug plan's performance**: Includes how often Medicare found problems with the plan, and how often members had problems with the plan, and how much the plan's performance has improved (if at all) over time.
3. **Member experience with the plan's drug services**: Includes ratings of member satisfaction with the plan.
4. **Drug safety and accuracy of drug pricing**: Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's considered safer and clinically recommended for their condition.

This information is gathered from several different sources like member surveys done by Medicare, reviews of billing and other information that plans submit to Medicare, and results from Medicare's regular monitoring activities.

What is the Medicare Advantage Open Enrollment Period (MA OEP)?

Starts Jan 1 → Continues Feb → Ends Mar 31

Coverage Begins first of month after you enroll

- 3-Month period each year during which you can
  - ✓ Switch MA Plans (MA to MA, MA-PD to MA, MA-PD to MA-PD, or MA to MA-PD)
  - ✓ Drop MA Plan and return to Original Medicare
    - If you do, you can enroll in a Part D plan
    - You won't have a guaranteed issue right for a Medigap policy
- You must already be in an MA Plan on January 1 to use this enrollment period
- Doesn't apply to Medical Savings Accounts (MSAs) or Cost Plans

Medicare Advantage and Other Health Plans

ADASTRA

The MA Open Enrollment Period (OEP) started in 2019. It's from January 1 – March 31 each year. Your coverage begins the 1st day of the month after you enroll in the plan. You must be in an MA Plan already on January 1 to use this enrollment period.

During the MA OEP you can

- Switch MA Plans (MA to MA, Medicare Advantage Prescription Drug Plan (MA-PD) to MA, MA-PD to MA-PD, or MA to MA-PD)
- Leave MA to join Original Medicare
  - There's a coordinating Part D Special Enrollment Period (SEP)
- Can add or drop Part D when switching plans
- Getting Part D isn't guaranteed unless you were in an MA Plan on January 1
- Can't switch from one standalone PDP to another standalone PDP

You can only make one change during the MA OEP.

Also, if you're new to Medicare and you're enrolled in an MA Plan during your Initial Coverage Election Period (ICEP), your MA OEP is the month of entitlement to Part A and Part B through to the last day of the 3rd month of entitlement.

MSAs and Cost Plans are not included in the MA OEP.

NOTE: The effective date for an MA OEP election is the 1st of the month following receipt of the enrollment request.

Medicare Advantage (MA) Trial Rights and Medigap

- Special Medigap rights for people who join an MA Plan for the first time
  - When first eligible at 65, or
  - Drop a Medigap policy
- Can disenroll during the first 12 months
  - Return to Original Medicare
  - Have guaranteed issue rights for Medigap

Medicare Advantage and Other Health Plans

AD ASTRA

If you join a Medicare Advantage (MA) Plan for the first time, you aren't happy with the plan, and return to Original Medicare within the first 12 months of joining, you'll have special rights to buy a Medicare Supplement Insurance (Medigap) policy if

- You joined an MA Plan when first eligible for Medicare at 65.
  - If you joined an MA Plan when you were first eligible for Medicare, you can choose from any Medigap policy within the first year of joining.
- You were in Original Medicare, enrolled in an MA Plan for the first time, and dropped a Medigap policy.
  - If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.

NOTE: The Medigap policy can't have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan. You can buy a Medigap policy anytime a plan will sell you one. Visit Medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf for more information about Medigap policies.

Types of Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Private Fee-for-Service
- Special Needs Plan
- Medicare Medical Savings Account

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare Advantage Plans include

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Private Fee-for-Service
- Special Needs Plan
- Medicare Medical Savings Account

Medicare Health Maintenance Organization (HMO) Plan

Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option in certain geographic areas.
Are prescription drugs covered?	In most cases, yes. Ask the plan. **If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.**
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do you need to know about this type of plan?	▪ If your doctor or other health care provider leaves the plan, your plan will notify you and you can choose another plan doctor. ▪ If you get health care outside the plan's network, you may have to pay the full cost. ▪ It's important that you follow the plan rules. For example, the plan may require prior approval for certain services.

Medicare Advantage and Other Health Plans

- In a Medicare Health Maintenance Organization (HMO) plan, you generally must get your care and services from doctors or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option.
    - In most cases, prescription drugs are covered. Ask the plan. If you want drug coverage, you must join an HMO plan that offers prescription drug coverage.
    - In most cases, you need to choose a primary care doctor and will have to get a referral to see a specialist. Certain services, like yearly screening mammograms, don't require a referral.
    - There are other things you should be aware of:
    - If your doctor leaves the plan, you usually can't leave the Medicare Advantage (MA) Plan until a valid enrollment period. Your plan will notify you and you can choose another doctor in the plan.
    - If you get care outside of the plan's network, you may have to pay the full cost.
    - It's important that you follow the plan rules. For example, the plan may require prior approval for certain services.

MA Plans can vary. Read individual plan materials carefully to make sure that you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Medicare Preferred Provider Organization (PPO) Plan

Can you get your health care from any doctor or hospital?	In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
Are prescription drugs covered?	In most cases, yes. **If you want Medicare drug coverage, you must join a PPO plan that offers prescription drug coverage.** You may contact individual plans to find out if they offer prescription drug coverage.
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	In most cases, no.
What else do you need to know about this type of plan?	▪ PPO plans aren't the same as Original Medicare or Medigap. ▪ Medicare PPO plans usually offer extra benefits (like dental or vision services) than Original Medicare, but you may have to pay extra for these benefits.

Medicare Advantage and Other Health Plans

- In a Medicare Preferred Provider Organization (PPO) plan you have PPO network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
- In most cases, prescription drugs are covered. If you want drug coverage, you must join a PPO plan that offers prescription drug coverage. You may contact individual plans to find out if they offer prescription drug coverage.
- You don't need to choose a primary care doctor, and you don't have to get a referral to see a specialist.
- There are other things you should be aware of:
    - PPO plans aren't the same as Original Medicare or Medigap (Medicare Supplement Health Insurance) policies.
    - Medicare PPO plans may also offer extra benefits that aren't available under Original Medicare, but you may have to pay extra for these benefits.

Medicare Advantage Plans in your area can vary. Read individual plan materials carefully to make sure that you understand the plan rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Medicare Private Fee-for-Service (PFFS) Plan

Can you get your health care from any doctor or hospital?	Yes. You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will. If you join a PFFS Plan that has a network, you can also see any of the network providers who've agreed to always treat plan members. You can choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more. Check with the plan for more information.
Are prescription drugs covered?	Sometimes. **If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan (Part D) to get coverage.**
Do you need to choose a primary care doctor?	No.
Do you need a referral to see a specialist?	No.

Medicare Advantage and Other Health Plans

- In a Medicare Private-Fee-for-Service (PFFS) Plan, you can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will.
- If you join a PFFS Plan that has a network, you can also see any of the network providers who've agreed to always treat plan members. You can choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms but you may pay more. Check with the plan for more information.
- Prescription drugs are sometimes covered. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare Prescription Drug Plan to get coverage.
- You don't need to choose a primary care doctor and you don't have to get a referral to see a specialist.

Additionally, all non-employer PFFS Plans must meet Medicare access requirements through contracts with providers if 2 or more network-based Medicare Advantage Plan options exist.

Medicare Private Fee-for-Service (PFFS) Plan (continued)

What else do you need to know about this type of plan?	▪ PFFS Plans aren't the same as Original Medicare or Medigap. ▪ The plan decides how much you must pay for services. ▪ Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before. ▪ Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before. ▪ Show your plan membership ID card each time you visit a health care provider. For each service you get, make sure that your doctors, hospitals, and other providers agree to treat you under the plan and accept the plan's payment terms. ▪ In an emergency, doctors, hospitals, and other providers must treat you.

Medicare Advantage and Other Health Plans

There are other things that you need to know about Medicare Private-Fee-for-Service (PFFS) Plans:

- PFFS Plans aren't the same as Original Medicare or Medigap
- The plan decides how much you must pay for services
- Some PFFS Plans contract with a network of providers who agree to always treat you even if you've never seen them before
- Out-of-network doctors, hospitals, and other providers may decide not to treat you even if you've seen them before
- For each service you get, make sure that your doctors, hospitals, and other providers agree to treat you under the plan and accept the plan's payment terms
- In an emergency, doctors, hospitals, and other providers must treat you

Medicare Advantage Plans can vary in benefits and costs. Read individual plan materials carefully to make sure that you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered, and how much it costs.

Medicare Special Needs Plans (SNPs)

Can you get your health care from any doctor or hospital?	You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
Are prescription drugs covered?	Yes. All SNPs must provide Medicare prescription drug coverage (Part D).
Do you need to choose a primary care doctor?	Generally, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

Medicare Advantage and Other Health Plans

Medicare Special Needs Plans (SNPs) are Medicare Advantage Plans that limit membership to people with specific diseases or characteristics.

- You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
- All SNPs must provide Medicare prescription drug coverage (Part D).
- You generally need to choose a primary care doctor.
- In most cases, you need a referral to see a specialist. Certain services, like yearly screening mammograms, don't require a referral.

Medicare Special Needs Plans (SNPs) (continued)

What else do you need to know about this type of plan?	▪ SNPs must limit plan membership to people in one of the following groups: 1. Institutional SNP (I-SNP): Those living in certain institutions (like a nursing home), or who require nursing facility-level of care at home 2. Dual Eligible SNP (D-SNP): Those eligible for both Medicare and Medicaid 3. Chronic Condition SNP (C-SNP): Those with specific chronic or disabling conditions ▪ Plans may further limit enrollment based on rules for the specific type of SNP ▪ Plans should coordinate your needed services and providers ▪ Plans should make sure that providers you use accept Medicaid if you have Medicare and Medicaid ▪ Plans should make sure that the plan's providers serve people where you live, if you live in an institution

Medicare Advantage and Other Health Plans

There are other things you need to know about Medicare Special Needs Plans (SNPs):

- SNPs must limit plan membership to people in one of the following groups:
  1. Institutional SNP (I-SNP): People who live in certain institutions (like a nursing home), or who require nursing facility-level care at home
  2. Dual Eligible SNP (D-SNP): People who are eligible for both Medicare and Medicaid
  3. Chronic Condition SNP (C-SNP): People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia)
- Plans may further limit enrollment based on rules for the specific type of SNP. For example, a D-SNP can further limit membership per the State Medicaid Agency Contract; an I-SNP enrollee must meet institutional level of care per the State requirements or the enrollee must agree to reside in a certain assisted living facility (within the network) if the enrollee meets that level of care; and, an a C-SNP can make further limitations per the chronic condition they are focusing on (i.e., a Cardiovascular/ Diabetes C-SNP can only enroll people who have cardiovascular disease or diabetes or both).
- Plans should coordinate the services and providers you need to help you stay healthy and follow your doctor's orders
- If you have Medicare and Medicaid, your plan should make sure that all of the doctors or other health care providers you use accept Medicaid
- If you live in an institution, make sure that the plan's doctors or other health care providers serve people where you live

Medicare Advantage Plans can vary. Read individual plan materials carefully to make sure that you understand the plan's rules. You may want to contact the plan to find out if the service you need is covered and how much it costs.

Medicare and Medical Savings Account Plans

- Combine a high-deductible insurance plan with a medical savings account
- Medicare deposits money into account
  - Use money to pay for health care services
  - No cost-sharing once the deductible has been paid
- Must cover Part A and Part B services, and except costs like dental, vision, and long-term care not covered by Medicare
- For drug coverage, must join a Part D plan

Medicare Advantage and Other Health Plans

AD ASTRA

There are other, less common types of MA Plans, like Medical Savings Account (MSA) Plans. MSA Plans combine a high-deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services. Cost-sharing isn't allowed once the deductible has been paid.

In addition to the Medicare Part A and Part B services that all MSA plans must cover, some MSA plans may cover extra benefits for an extra cost, like dental, vision, and long-term care not covered by Medicare.

If you join an MSA plan, you'll need to join a Part D plan to get drug coverage.

Medicare Advantage (MA) Plan Network Changes

- Many types of MA Plans have provider networks
- Plans may change networks at any time
  - Must protect you from interruptions in medical care
  - Must maintain adequate access to services
  - Must notify enrollees who see affected providers
    - At least 30 days prior to the provider's contract termination
- In most cases, network changes aren't a basis for a Special Enrollment Period
  - CMS determines eligibility on a case-by-case basis

Medicare Advantage and Other Health Plans

Network-based Medicare Advantage (MA) Plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations, and Private Fee-for-Service Plans with networks) can make changes to their network of contracted providers at any time during the year. It's important to note that the Centers for Medicare & Medicaid Services (CMS) has safeguards in place to ensure that you are protected from medical care interruptions.

For example, CMS requires plans to maintain continuity of care for impacted enrollees by making sure you have access to medically necessary services if you need it.

- When MA Plans make changes to their networks, CMS also requires that they maintain adequate access to all medically necessary Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) services through their remaining provider network. If the remaining network doesn't meet Medicare access and availability standards, plans must add new providers necessary to meet CMS's access requirements.
- Also, when an MA Plan makes a change in its provider network, it must provide written notification to enrollees who are seen on a regular basis by the provider whose contract is ending. This notice must be given at least 30 days in advance of the termination date. In this notice, the plan must provide a list of alternative providers and allow you to choose another provider.
- In most cases, mid-year provider network changes aren't a basis for an Enrollment Exception/Special Enrollment Period (SEP). CMS determines SEPs in these instances, on a case-by-case basis.

An MA organization and a contracting provider must provide at least 60 days written notice to each other before terminating a contract without cause. A contract between an MA organization and a contracting provider may require notification of termination without cause for a longer period of time. CMS doesn't get involved in contracting disputes.

Program of All-inclusive Care for the Elderly (PACE) Plans

- Is a Medicare and Medicaid Program
- Combines services for frail, elderly people
  - Medical, social, and long-term care services
  - Includes prescription drug coverage
- Alternative to nursing home care
- Only in states that offer it under Medicaid
- Three PACE programs available in Kansas
  - Via Christi HOPE, Midland Care Services, and Bluestem PACE

Medicare Advantage and Other Health Plans

AD ASTRA

Programs of All-inclusive Care for the Elderly (PACE) is a joint Medicare and Medicaid Program that helps frail elderly people meet their health care needs in the community instead of going to a nursing home or other care facility. PACE provides all medically necessary services, including prescription drugs. Based on the circumstances, PACE might be a better choice for some people instead of getting care through a nursing home. PACE may be available in states that have chosen it as an optional Medicaid benefit. The qualifications for PACE vary from state to state.

NOTE: There are three PACE programs available in Kansas.

Via Christi HOPE: if you live in **Sedgwick County**

Call **316-858-1111** You can also visit Via Christi's website by clicking here.

Midland Care Services: if you live in **Douglas, Jackson, Jefferson, Lyon, Marshall, Nemaha, Osage**, **Shawnee, Pottawatomie or Wabaunsee Counties**

Call **785-232-2044 Midland** has also been awarded the areas to expand in Brown, Atchison and Doniphan counties. You can also visit Midland's website by clicking here.

Bluestem Communities of Hesston: if you live in **McPherson, Ottawa, Lincoln, Ellsworth, Saline, Dickinson, Rice, Marion, Reno or Harvey counties**

Call **316-284-2900** Bluestem has also been awarded areas to expand in Jewell, Republic, Washington, Mitchell, Clay, Cloud, Riley, Geary, Morris and Chase counties. You can also visit Bluestem's website by clicking here.

Marketing Materials

- Plan communications (activities and use of materials to provide information to current and prospective enrollees) versus marketing (activities and use of materials by the health or dug plan with the intent to draw a person with Medicare's attention to a plan or plans, and influence their decision to join or stay in a plan)
- The Centers for Medicare & Medicaid Services (CMS) requires review and approval of certain materials
  - Exceptions are listed in Section 100 of the Medicare Communications & Marketing Guidelines (MCMG).
  - Plans must maintain materials and make them available at CMS's request
- CMS creates standardized and model marketing materials
- For more information visit CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf

Medicare Advantage and Other Health Plans

AD ASTRA

The Medicare Communications & Marketing Guidelines (MCMG) defines communications as activities and use of materials to provide information to current and prospective enrollees. It defines marketing as a subset of communications. Marketing includes activities and use of materials by the health or drug plan with the intent to draw a person with Medicare's attention to a plan or plans, and to influence their decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing).

- The Centers for Medicare & Medicaid Services (CMS) requires the review and approval of certain marketing materials, with the exception of those in Section 100 of the MCMG. While not an exhaustive list, some examples of excluded materials include the following:
  - Certain member newsletters
  - Press releases—if benefit information is included, it must be submitted for review
  - Blank letterhead
  - Privacy notices
  - Ad hoc materials as defined in Appendix 1 of the MCMG
- Although certain materials aren't subject to the review and approval process that applies to marketing materials, plans must maintain materials and make them available at CMS's request.
- Medicare health and drug plans must use standardized marketing material language and format, without modification (except where specified by CMS). Examples of standardized documents include, but aren't limited to
  - Plan Annual Notice of Change (ANOC)
  - Evidence of Coverage (EOC)
- CMS also creates model communications materials, such as the provider and pharmacy directories.

Marketing Reminders

- Marketing for upcoming plan year
  - May not occur before October 1
- Marketing star ratings in materials must get equal or greater prominence
  - Individual measures may be marketed/ communicated with overall performance rating
  - Low-performing star rating status
    - Low Performance Icon (LPI)
    - Plans may not try to discredit their LPI status by showcasing a separate higher rating

Medicare Advantage and Other Health Plans

AD ASTRA

Marketing for the upcoming plan year may not occur before October 1. Plan sponsors must stop current year marketing activities to existing people with Medicare once they begin marketing the plan benefits for the new contract year.

Medicare Advantage (MA), Medicare Advantage with Prescription Drug (MA-PD), and Prescription Drug Plans (PDPs) get plan star ratings from CMS. Many individual performance measurements are used to determine the CMS overall star rating. When referencing a plan's ratings in marketing materials

- Individual measures may be marketed only with the overall star rating. The overall star rating must get equal prominence as individual measure(s) being marketed.
- Medicare Health Plans and Part D sponsors that have a Low Performance Icon (LPI) due to a low Part C (MA Plan) or Part D (PDPs) rating may not try to refute or discredit their LPI status by only showcasing a higher overall star rating. Any communications in reference to the LPI status must state what the status means.

NOTE: A contract that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years (i.e., rated 2.5 or fewer stars for the 2014, 2015, and 2016 plan ratings for Part C or Part D) will be marked with the above icon on Medicare Plan Finder.

Disclosure of Plan Information for New and Renewing Members

- MAs and PDPs must disclose plan information at time of enrollment and at least annually
- Notification of Availability of Electronic Materials—***Without*** prior enrollee authorization
  - Describe where required materials can be found online and how to request a hard copy
    - Evidence of Coverage (EOC)
    - Pharmacy directory (for all plans offering a Part D benefit)
    - Provider directory (for all plan types except PDPs)
    - Formulary
- Electronic Delivery of Required Materials—***With*** prior enrollee consent
  - Materials in different media types (e.g., hard copy, email, web portal, CD, DVD)
    - Annual Notice of Change (ANOC)
    - ANOC and EOC Errata (describes errors found in an earlier version of an ANOC or EOC)
    - Enrollment and Disenrollment notices
- Documents for new enrollees must be provided no later than 10 calendar days or the last day of the month before the effective date, whichever is later

Medicare Advantage and Other Health Plans

AD ASTRA

To ensure that enrollees get comprehensive plan information regarding their health care options, CMS requires MA and Part D Plans to disclose certain plan information both at the time of enrollment and at least annually.

- MCMG Section 100.2.1 (Notification of Availability of Electronic Materials)—***Without*** prior beneficiary authorization, health and drug plans may send new and current (i.e., not prospective) enrollees a notice(s) informing them how to electronically access the CMS designated required materials listed below instead of mailing hard copies of the documents. They must also tell them how to request a hard copy, if wanted. These notices must be sent in time for an enrollee to receive them by October 15 of each year (but no earlier than September 1).
  - Evidence of Coverage (EOC)
  - Pharmacy directory (for all plans offering a Part D benefit)
  - Provider directory (for all plan types except PDPs)
  - Formulary (for all plans offering a Part D benefit)
- MCMG Section 100.2.2 (Electronic Delivery of Required Materials)— In addition to providing electronic access to the materials listed above in 100.2.1, with prior consent from the enrollee, health and drug plans can provide any materials in different media types (e.g., hard copy, email, web portal, CD, DVD). Plans must obtain prior consent from the enrollee; specify both the media type and the specific materials; and provide an opt-out mechanism so enrollees can receive hard copies. Following are some examples of materials that are included in this section:
  - The standardized Annual Notice of Change (ANOC which the enrollee gets it by October 1 and is posted to plan's website by October 15.
  - The ANOC and EOC Errata, which describes errors found in an earlier version of an ANOC or EOC.
  - Enrollment and Disenrollment notices.
- Plans are expected to provide required documents for new enrollees no later than 10-calendar days after getting CMS's confirmation of enrollment, or by the last day of the month before the effective date, whichever is later.

NEW Changes to the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

- Plans may send ANOC and EOC separately
- ANOC still due to enrollees by October 1
- EOC now due to enrollees by October 15
- Plans may now distribute EOC (and some other required documents, like directories) electronically
  - May post on a website but must send hard copy notice that documents are available

Medicare Advantage and Other Health Plans

AD ASTRA

CMS will change plan requirements for how plans mail and communicate the ANOC and EOC documents to their members.

- Plans may send the ANOC and EOC separately.
- The ANOC is still due to enrollees by October 1.
- The EOC (and some other required documents, like directories) is now due to enrollees by October 15.
- Plans may now distribute the EOC and directories electronically. Plans may choose to post the EOC and directories on a website, but they must send a hard copy notice that documents are available.

Nominal Gift Reminders

- Organizations can offer gifts to potential enrollees
  - Must be of nominal value
    - Defined in Medicare Marketing Guidelines
    - Currently $15 or less per individual gift based on retail value
    - There's a maximum aggregate of all gifts of $75 per person, per year
- Given regardless of beneficiary enrollment and without discrimination
- May not be in the form of cash or other monetary rebates
  - Gift cards are acceptable, if they can't be converted into cash

Medicare Advantage and Other Health Plans

AD ASTRA

Organizations can offer gifts without discrimination to potential enrollees as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. The Centers for Medicare & Medicaid Services currently defines nominal value in the Medicare Marketing Guidelines (MMG), Section 70.1, as an item worth $15 or less, based on the fair market value of the item. There's a maximum aggregate of $75 per person, per year. Nominal gifts may not be in the form of cash or other monetary rebates. Gift cards are acceptable, if they can't be converted into cash.

NOTE: For more information, see the link to the MMG on the resources page near the end of this presentation.

Unsolicited Beneficiary Contact

- Prohibited unsolicited marketing activities
  - Electronic communications
    - Unless express permission is given
  - Door-to-door solicitation
  - Calls/visits after attending sales event
    - Unless permission is given
  - Common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: Prohibited activities don't include conventional mail or other print media

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare health plans and Part D (Medicare prescription drug coverage) sponsors may not initiate separate electronic or direct contact with a person with Medicare unless they have agreed to get this communication. For example, on social media websites, such as Facebook and Twitter, if a person with Medicare comments or likes a plan/Part D sponsor on the site, that doesn't give permission to directly contact.

The current prohibition on door-to-door solicitation extends to other instances of unsolicited contact that may occur outside of sales or educational events. Prohibited activities include, but aren't limited to

- Outbound marketing calls, unless the beneficiary requested the call
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, in market plans or products
- Calls to people with Medicare to confirm receipt of mailed information
- Calls to people with Medicare to confirm acceptance of appointments made by third parties or independent agents
- Soliciting to people with Medicare when held in common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: These marketing prohibitions don't include conventional mail or other print media

Organizations may do the following:

- Make outbound calls to existing members to conduct normal business related to enrollment in the plan
- Call former members after the disenrollment effective date to conduct a disenrollment survey for quality improvement purposes
- Contact their members who are eligible for Extra Help, call people with Medicare (with CMS Regional Office approval), and contact people with Medicare who have expressly given permission for a plan or sales agent to contact them (e.g., completing a business reply card)

Cross-Selling Prohibition

- Prohibited during any Medicare Advantage or Part D sales activity or presentation
- Can't market non-health related products
  - Annuities
  - Life insurance
  - Other products
- Allowed on inbound calls per the request of the person with Medicare

Medicare Advantage and Other Health Plans

AD ASTRA

Marketing health care-related products (such as annuities, life insurance, etc.) to prospective enrollees during any Medicare Advantage (MA) or Part D (Medicare prescription drug coverage) sales activity or presentation is considered cross-selling and is a prohibited activity.

People with Medicare already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion. Plans should not imply that the health and the non-health products are a package. Plans may sell non-health-related products on inbound calls when a person with Medicare requests information on other non-health-related products. Marketing to current plan members of non–MA Plan-covered health care products, and/or non–health care products, is subject to Health Insurance Portability and Accountability Act (known as HIPAA) rules.

Scope of Appointment Reminders

- Must specify product type
  - Medicare Advantage, Medicare Prescription Drug, and Cost Plans
- 48 hours before personal/individual marketing and/or in-home appointment
- Additional products can only be discussed
  - With person with Medicare's request
  - At separate appointment

Medicare Advantage and Other Health Plans

AD ASTRA

The Medicare Marketing Guidelines require marketing representatives to clearly identify the types of products they will discuss before marketing to a potential enrollee. Marketing representatives who initially meet with a person with Medicare to discuss specific lines of plan business (separate lines of business include Medicare Advantage, Medicare Prescription Drug, and Cost Plans) must tell the person with Medicare about all products they will discuss before the in-home appointment so they have accurate information to make an informed decision about their Medicare coverage choices without pressure.

- Before a marketing appointment, the person with Medicare must agree to the scope of the appointment. The plan can document the scope of the appointment in writing or telephone recording. The person with Medicare may sign the scope of appointment at least 48 hours before the scheduled appointment, when practicable. If the agent is unable to get the signature 48 hours in advance, the agent should document the reason.

Example: A person with Medicare attends a sales presentation and schedules an appointment. The agent must get the person with Medicare to sign written documentation agreeing to the products that will be discussed during the appointment.

- Organizations should use their existing systems to monitor and track calls where there's interaction with people with Medicare. Organizations that contact a person with Medicare in response to a reply card may only discuss the products that were included in the advertisement.
- Organizations may not discuss additional products unless the person with Medicare requests the information. Moreover, any additional lines of plan business that aren't identified before the in-home appointment will require a separate appointment.

Promotional Activity Reminders

- Prospective enrollees may not be given meals or have meals subsidized at sales/marketing events
- Refreshments and light snacks may be given
- Items given can't be reasonably considered a meal and/or that multiple items are not being "bundled" and given as if a meal

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare health and drug plans may not give prospective enrollees meals, or subsidize meals, at sales events or any meeting at which they discuss plan benefits and/or distribute plan materials.

Agents and/or brokers are allowed to provide refreshments and light snacks to prospective enrollees. Plans must use their best judgment on the appropriateness of food products they provide, and must ensure that items they provide couldn't be reasonably considered a meal, and/or that they aren't "bundling" and providing multiple items as if they are a meal.

As with all marketing regulations and guidelines, it's the responsibility of the plan to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities CMS conducts will verify that plans and agents are complying with this provision, and CMS will take enforcement actions.

Educational Event Reminders

- Must be advertised as educational
- May set up a future marketing appointment, and distribute business cards and contact information (includes completing and collecting a Scope of Appointment (SOA) form)
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms during the educational event
- Plans may conduct marketing/sales events immediately following an educational event in the same general location (e.g., same hotel)

Medicare Advantage and Other Health Plans

AD ASTRA

Educational events are designed to inform people with Medicare about MA, prescription drug, or other Medicare Programs.

Educational events:

- Must be explicitly advertised as educational
- May set up a future marketing appointment, and distribute business cards and contact information for people with Medicare to initiate contact (this includes completing and collecting a Scope of Appointment (SOA) form)
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms during the educational event
- Plans may conduct marketing/sales events immediately following an educational event in the same general location (e.g., same hotel)

For more information on educational events, visit CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf.

Marketing/Sales Events

- Health and drug plans must submit talking points and presentations to CMS prior to use including those to be used by agents/brokers
- Sign in sheets must clearly be labeled as optional
- Health screenings or other activities that may be perceived as, or used for, "cherry picking" are not permitted
- Health and drug plans may not require attendees to provide contact information as a prerequisite for attending an event
- Contact information provided for raffles or drawings may only be used for that purpose

NOTE: The MCMG gives direction to plans on where their marketing or sales events may or may not take place.

AD ASTRA

Medicare Advantage and Other Health Plans

Marketing/Sales Events are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans. The following requirements apply to all marketing/sales events:

- Health and drug plans must submit talking points, if applicable, and presentations to CMS prior to use, including those to be used by agents/brokers
- Sign in sheets must clearly be labeled as optional
- Health screenings or other activities that may be perceived as, or used for, "cherry picking" aren't permitted
- Health and drug plans may not require attendees to provide contact information as a prerequisite for attending an event
- Contact information provided for raffles or drawings may only be used for that purpose

NOTE: The MCMG gives direction to plans on where their marketing or sales events may or may not take place.

For more information on marketing and sales events, visit CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf.

Licensure, Appointment, and Termination of Agents and Brokers

- MA and Part D Plan agents/brokers or other marketing representatives
  - Must comply with state-licensure laws
    - Applies to all agents/brokers
  - Must be appointed by the plan, if required by the state
- Plans must report termination of agents/brokers to
  - State(s), per state law
  - CMS Account Manager (for-cause terminations)

Medicare Advantage and Other Health Plans

102

AD ASTRA

Health and drug plans that conduct marketing through agents, brokers, and other marketing representatives must comply with state licensure and appointment laws to give the state information about which agents are marketing MA and Part D Plans.

Some plan activities, typically carried out by the plan's customer service department, don't require the use of state-licensed marketing representatives, such as providing factual information or fulfilling a request for materials.

Health and drug plans must report the termination of any brokers or agents, and the reasons for the termination, to the state(s) if required. In addition, any for-cause terminations (specific legal or organizational policy violations that made it necessary to terminate employment) must be reported to the CMS Account Manager, by email or letter.

Agent/Broker Training and Testing

- All agents/brokers must be trained and tested annually
  - Medicare rules and regulations
  - Plan details specific to plan products sold
  - Applies to all agents/brokers
- Completed prior to marketing the product
  - Must pass test with 85%

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare Advantage Organizations and Part D plan sponsors must ensure that brokers and agents selling Medicare products are trained and tested annually on Medicare rules and regulations, and on plan details specific to the plan products they are selling. This requirement applies to all agents. Agents and brokers must pass a test with a score of 85% before to marketing products.

Rewards and Incentives

- Applies to MA Plans only and must
  - Not be used in exchange for enrollment
  - Be provided to all potential enrollees without discrimination
- Nominal gifts are different from rewards and incentives
- CFR 422.134 expands rewards and incentive programs
- MedicareManagedCareManual-Chapter 4

Medicare Advantage and Other Health Plans

MA Plans may include information about rewards and incentive programs in marketing materials for potential enrollees. Marketing of rewards and incentive programs must

- Not be used in exchange for enrollment
- Be provided to all potential enrollees without discrimination

Nominal gifts that are part of marketing activity are different from rewards and incentives.

Part D plans are not permitted by 42 CFR § 422.134 to develop or use rewards and incentive programs. Therefore, Part D Plans may not market reward and incentive programs.

NOTE: For more information, see Chapter 4 of the "Medicare Managed Care Manual," MedicareManagedCareManual-Chapter 4.

Medicare Supplement Insurance (Medigap) Policies

- Medigap policies are private health insurance that
  - Supplement Original Medicare
    - You must have both Medicare Part A and Part B to get a Medigap policy
    - You pay a monthly premium to the insurer and also pay the Part B monthly premium
  - Help pay some health care costs that Original Medicare doesn't cover (coverage "gaps")
    - Medicare will pay its share of the Medicare-approved amounts for covered health care costs
      - Then your Medigap policy pays its share
    - A Medigap policy covers one person

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

A Medicare Supplement Insurance policy (often called Medigap) is private health insurance that's designed to supplement Original Medicare.

This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). These are "gaps" in Medicare coverage. If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share.

- You must have both Medicare Part A and Part B to get a Medigap policy.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to your monthly Part B premium.

Medigap policies cover only one person. If you and your spouse both want Medigap coverage, you'll need to have separate Medigap policies.

Medigap Plans

- Sold by private insurance companies
- Fills gaps in Original Medicare coverage
  - Deductibles, coinsurance, copayments
- All plans with same letter
  - Have same coverage
  - Costs are different
- Plans are different in Minnesota, Massachusetts, and Wisconsin
- You must have Medicare Part A (Hospital Insurance and Part B (Medical Insurance)

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

A Medigap policy is private health insurance that's designed to supplement Original Medicare. This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then, your Medigap policy pays its share. Some Medigap policies also cover certain benefits Original Medicare doesn't cover. You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to buy a Medigap policy.

Medigap policies don't cover your share of the costs under other types of health coverage, including Medicare Advantage (MA) Plans, stand-alone Medicare Prescription Drug Plans (PDPs), employer/union group health coverage (GHP), Medicaid, Department of Veterans Affairs (VA) benefits, or TRICARE. Also, in some cases it may be illegal for the insurance company to sell you a Medigap policy (like if you already have Medicaid or a Medicare Advantage Plan).

Medigap policies cover only one person. If you and your spouse both want Medigap coverage, you'll need to buy separate Medigap policies.

You still pay the monthly Part B premium.

Medigap Plan Types

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2020**							$5,880	$2,940		

Plans C & F are not available for individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.
*Plans F & G are also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,340 in 2020 before your policy pays anything.
**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Medicare Supplement Insurance (Medigap) Policies

All Medigap policies cover a basic set of benefits, including the following:

- All plans cover 100% of Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up. Plans F & G also offer a high-deductible plan, $2,340 in 2020.
- Medicare Part B coinsurance or copayment, with Plans A, B, C, D, F, G, M, and N covering 100%. Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits, and up to a $50 copayment for emergency room visits that don't result in an inpatient admission. Plan K pays 50% of Medicare Part B coinsurance or copayment, with Plan L paying 75%.
- Blood (first 3 pints) with Plans A, B, C, D, F, G, M, and N covering 100%; Plan K 50%; and Plan L 75%.
- Part A hospice care coinsurance or copayment with Plans A, B, C, D, F, G, M, N covering 100%; Plan K 50%; and Plan L 75%.
- In addition, each Medigap plan covers different benefits:
  - The skilled nursing facility care coinsurance is covered 100% by Plans C, D, F, G, M, and N covering 100%; Plan K 50%; and Plan L 75%.
  - The Medicare Part A deductible is covered 100% by Plans B, C, D, F, G, and N; Plans K and M 50%; and Plan L 75%.
  - The Medicare Part B deductible is 100% covered by Medigap Plans C and F.
  - The Medicare Part B excess charges are covered 100% by Medigap Plans F and G.
  - Foreign travel emergency costs up to the plans' limits are covered at 80% by Medigap Plans C, D, F, G, M, and N.

In 2020, Plans K and L have out-of-pocket limits of $5,880 and $2,940, respectively.

2020 Medigap Changes

- On or after January 1, 2020, no standardized Medigap policy may provide coverage of the Part B deductible
  - Insurance companies are prohibited from selling standardized Plans C or F to newly eligible people with Medicare
    - Turning 65 as of January 1, 2020, or later
    - Getting premium-free Part A as of January 1, 2020, or later
  - A person who isn't "newly eligible for Medicare" on January 1, 2020, or later can apply to buy Plan C or F but this doesn't qualify as a guaranteed issue right to buy it.
  - Insurance companies may sell Plans C or F to those getting Medicare retroactively with Part A start date before January 1, 2020

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation signed into law on April 16, 2015. It changed who's eligible to purchase a Medigap policy that provides coverage of the Part B deductible.

- This refers to Plans C and F.
- Insurance companies selling Medigap policies can't sell Plans C or F to people who turn 65 on January 1, 2020, or later, or to people who get premium-free Part A (due to a disability or ESRD) as of January 1, 2020, or later.
- A person who isn't a "newly eligible Medicare beneficiary" on January 1, 2020, or later can apply to buy Plan C or F and the insurance company is allowed to sell the policy by MACRA. The insurance company isn't required to sell the policy because a guaranteed issue right isn't active.
- Insurance companies can sell a Plan C or F to a person who gets retroactive Medicare premium-free Part A before January 1, 2020.

2020 Medigap Changes (continued)

- Plans C and F will remain active for people who already had them
- Plans C and F are guaranteed renewable
  - Unless the premiums aren't paid
- No federal guaranteed issue right to transfer from Plans C or F to other plan types
- Check with your state

NOTE: Plans C and F may continue to be offered to people who became eligible for Medicare prior to January 1, 2020

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

Medigap Plans C and F will remain active for those people who already had them; however, the enrollment pools will be closed. Plans C and F are guaranteed renewable for those who already have them. If the premiums aren't paid, these plans would be lost and they won't be able to get either of them back.

There won't be a federal guaranteed issue right for people with Plan C or F to change to other plan types. Check with your State Insurance Department about what rights you might have under state law.

NOTE: Plans C and F may continue to be offered to people who became eligible for Medicare prior to January 1, 2020

How Are Medigap Policies and Medicare Advantage (MA) Plans Different?

	Medicare Supplement (Medigap) Insurance	Medicare Advantage Plans (Part C)
Offered by	Private companies	Private companies
Government oversight	State, but must also follow federal laws	Federal (plans must be approved by Medicare)
Works with	Original Medicare	N/A
Covers	Gaps in Original Medicare coverage, like deductibles, coinsurance, and copayments for Medicare-covered services.	All Part A and Part B covered services and supplies. May also cover things not covered by Original Medicare, like vision and dental coverage. Most MA Plans include Medicare prescription drug coverage.
You must have	Part A and Part B	Part A and Part B
Do you pay a premium	Yes. You pay a premium for the policy and you pay the Part B premium.	Yes. In most cases you pay a premium for the plan and you pay the Part B premium.

Medicare Supplement Insurance (Medigap) Policies

This chart displays a side-by-side comparison of how Medigap policies and Medicare Advantage (MA) Plans differ.

- Both are offered by private companies.
- Medigap must follow federal and state laws, but routine day-to-day oversight of standardized Medigap plans is the states' responsibility. MA Plans must be approved by Medicare.
- Medigap only works with Original Medicare. MA Plans don't work with Medigap policies. If you join an MA Plan, you can't use a Medigap policy to pay for the out-of-pocket costs you have in the MA Plan.
- Original Medicare pays for many, but not all, health care services and supplies. Private insurance companies sell Medigap policies to help pay for some of the out-of-pocket costs ("gaps") that Original Medicare doesn't cover. Medigap policies don't pay your Medicare premiums. Most Medigap policies don't cover out-of-pocket drug expenses. If you want prescription drug coverage you'd need to consider joining a Part D plan. Some older policies (no longer sold) may have included some drug expense coverage (Plan I). MA Plans cover Part A and Part B covered services, may include Part D, and may offer extra coverage like vision, hearing, dental, and wellness programs.
- In both cases, you must have Part A and Part B to join.
- You pay a premium for a Medigap policy or an MA Plan, as well as the Part B premium.
- If you already have an MA Plan, it's illegal for anyone to sell you a Medigap policy unless you're disenrolling from your MA Plan to go back to Original Medicare.

Medigap Policies

- You pay a monthly premium
- Costs vary by plan, company, your age, and location
- Follow federal/state laws that protect you
- Six Month Medigap Open Enrollment Period –Starts when you're both 65 and signed up for Part B
  - Once started, it can't be delayed or repeated
- Doesn't work with Medicare Advantage
- No networks except with a Medicare SELECT policy

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

You pay a monthly premium for a Medigap policy to the insurance company that sells it. With a Medigap policy, costs can vary by plan, company, your age, and location.

Must follow federal and state laws that protect people with Medicare.

Your Medigap Open Enrollment Period (OEP) starts when you're both 65 and signed up for Part B. Once it has started, it can't be delayed or repeated. During your Medigap OEP, an insurance company can't

- Use medical underwriting (a process insurance companies use to decide, based on your medical history, whether to accept your application for insurance, whether to add a waiting period for pre-existing conditions, and how much to charge you.)
- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except in certain pre-existing circumstances)

You can buy a Medigap policy any time a company will sell you one.

Medigap policies don't work with Medicare Advantage Plans.

Medigap policies pay for Medicare-covered services provided by any doctor, hospital, or provider that accepts Medicare.

The exception is Medicare SELECT policies that require you use specific hospitals, and in some cases, specific doctors to get full benefits.

Medicare SELECT Policies

- A type of Medigap policy with a network
- To get full benefits (except in emergency)
  - Must use specific hospitals, and
  - May have to see specific doctors
- Can be any of the standardized policies
- Generally cost less than non-network policies
- Can switch to plan with equal or lesser value at any time
- Not available in all states

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be any of the standardized Medigap policies.

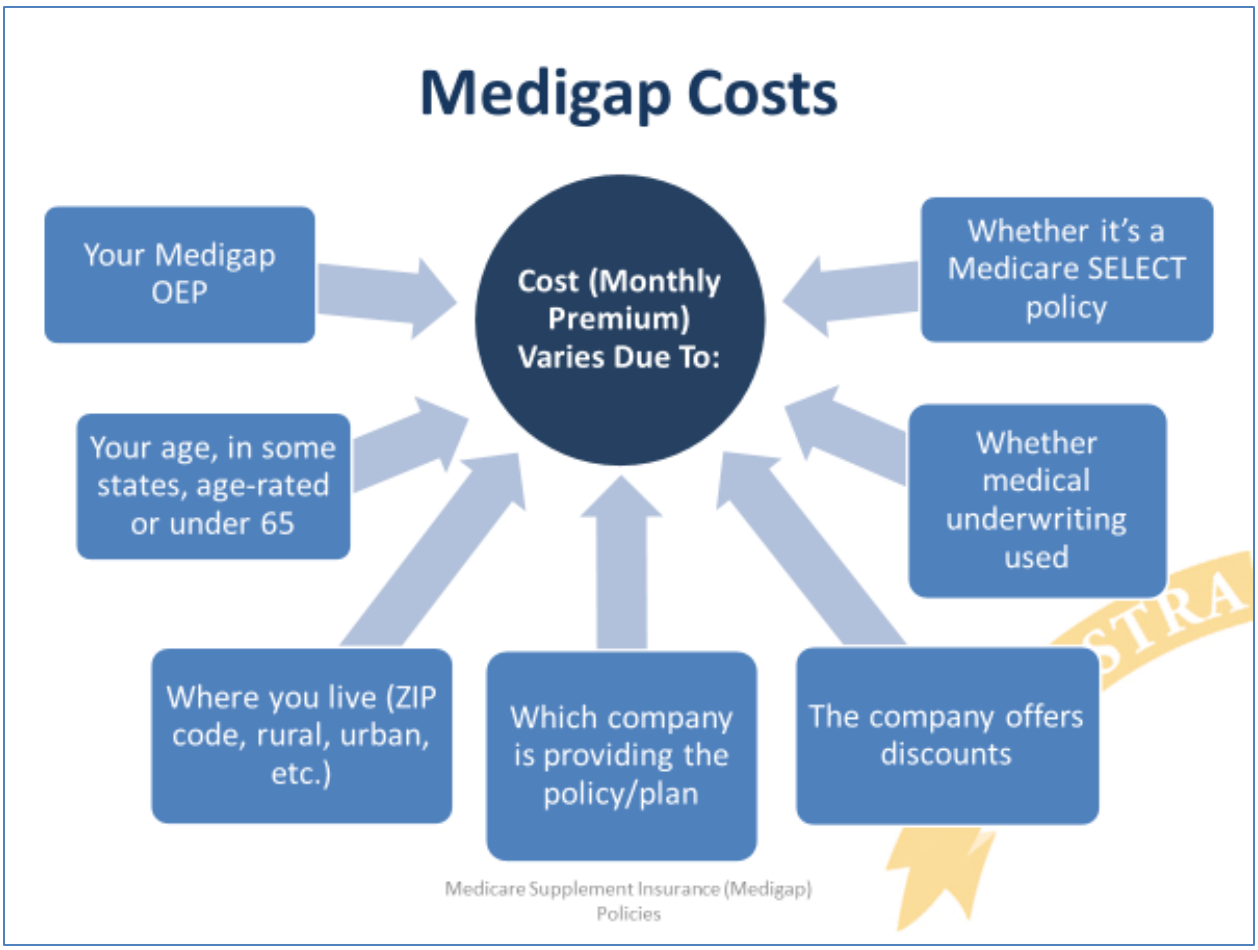
These policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT network hospital or doctor for non-emergency services, you'll have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

If you currently have a Medicare SELECT policy, you also have the right to switch, at any time, to any regular Medigap policy being sold by the same company. The Medigap policy you switch to must have equal or less value than the Medicare SELECT policy you currently have.

If you have a Medicare SELECT policy and you move out of the policy's area, you

- Can buy a standardized Medigap policy from your current Medigap insurance company that offers the same or fewer benefits than your current Medicare SELECT policy. If you've had your Medicare SELECT policy for more than 6 months, you won't have to answer any medical questions.
- Have a guaranteed issue right to buy any Medigap Plan A, B, C, F, K, or L that's available for sale in most states by any insurance company.

Medicare SELECT policies aren't available in all states. To see what's available in your state, call your State Insurance Department. Visit Medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf to get your state's contact information. You can also call your State Health Insurance Assistance Program (SHIP) (1-877-839-2675) or visit shiptacenter.org/ for more information, and to locate the SHIP in your state.



There can be big differences in the premiums that different insurance companies charge for exactly the same coverage.

If you buy your policy during your Medigap Open Enrollment Period (OEP), you get the best cost. How much you pay can depend on

- Your age. In some states, people under 65 can't buy a Medigap policy, and some states allow companies to sell Medigap policies that could cost more based on whether you're older when you buy it (age-rated) or when you get older (attained-age rated). See next slide for more details.
- Where you live (for example, in an urban or rural area, or by ZIP code).
- The company selling the policy and the plan you buy (for instance, if it's a high-deductible Plan F or had more benefits).
- Whether the insurance company offers discounts (like discounts for women, non-smokers, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- Whether the insurance company uses medical underwriting (reviews your medical history to decide whether to accept your application, and adds a waiting period for a pre-existing condition, if your state law allows it); or applies a different premium when you don't have a guaranteed issue right (see Lesson 4), or you aren't in your Medigap OEP.
- Whether the insurance company sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be lower.

Medigap Pricing Based on Age

Type of Rating	Description
No-age-rated (community-rated)	▪ Everyone pays same regardless of age if 65 or older ▪ Generally least expensive over lifetime
Issue-age-rated	▪ Based on age when purchased ▪ Doesn't go up automatically as you get older
Attained-age-rated	▪ Premium based on current age ▪ Costs less when you're 65 ▪ Cost goes up each year as you get older
Premiums may go up due to inflation and other factors. Not all states allow all 3 types of ratings.	

Medicare Supplement Insurance (Medigap) Policies

Insurance companies have 3 ways to price policies based on your age. Not all states allow all 3 types:

1. **No-age-rated (also called community-rated) policies**—These policies charge everyone the same rate no matter how old they are. In general, no-age-rated Medigap policies are the least expensive over your lifetime. If people with Medicare under 65 have the right to buy a policy, premiums can be rated differently, and they may be charged more. Premiums may go up because of inflation and other factors, but not because of your age.
2. **Issue-age-rated policies**—The premium for these policies is based on your age when you first buy the policy. Premiums are lower for people who buy at a younger age. Premiums may go up because of inflation and other factors, but not because of your age.
3. **Attained-age-rated policies**—The premiums for these policies are based on your age each year. These policies are generally cheaper at 65, but their premiums go up automatically as you get older. In general, attained-age-rated policies cost less when you're 65 than issue-age-rated or no-age-rated policies. However, when you reach 70 to 75, attained-age-rated policies usually become the most expensive. Premiums may also go up because of inflation and other factors.

When you compare premiums, be sure you're comparing the same Medigap Plan A–N.

The Best Time to Buy a Medigap Policy

- Your Medigap Open Enrollment Period (OEP)
  - 6 months when insurance company must sell you a plan
  - Guaranteed issue period without medical underwriting
  - Your one OEP begins when you're 65 or older **and** enrolled in Part B
    - Can't be changed or repeated
  - Some states have more generous rules
- May be able to buy a Medigap policy any time an insurance company will sell you one

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

It's very important to understand your Medigap Open Enrollment Period (OEP). The best time to buy a Medigap policy is during your Medigap OEP. This period lasts for 6 months. It begins on the first day of the month in which you're both 65 or older **and** enrolled in Medicare
Part B. If you apply during your Medigap OEP, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health. If you don't buy a plan within your 6-month OEP, insurance companies can deny coverage based on your health condition.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap OEP begins when you enroll in Part B, and it can't be changed or repeated. In most cases, it makes sense to enroll in Part B and buy a Medigap policy when you're first eligible for Medicare. This is because you might otherwise have to pay a Part B late enrollment penalty, and you might miss your Medigap OEP. However, there are exceptions if you have employer coverage.

While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition. Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket expenses. You may buy a Medigap policy any time an insurance company will sell you one.

NOTE: Some states have additional Medigap rights, including those for people with Medicare under 65. Kansas requires all Medigap insurers to allow a 6-month Medigap OEP to all people with Medicare, including those under 65. Those under 65 will have another Medigap OEP when they turn 65.

Delayed Medigap Open Enrollment Period (OEP)

- If you delay enrolling in Medicare Part B
  - Because you or your spouse is still working, and
  - You have group health coverage
- Medigap OEP is delayed
  - Until you're 65 **and** enrolled in Part B
  - No late enrollment penalty
- Notify Social Security to delay Part B

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

If you have group health coverage through an employer or union because either you or your spouse is currently actively working, you may want to wait to enroll in Medicare Part B. This is because

- Benefits based on current employment often provide coverage similar to Part B.
- You would be paying for Part B before you need it.
- Your Medigap Open Enrollment Period (OEP) might expire before a Medigap policy would be useful.

When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty, which means your Medigap OEP will start when you're ready to take advantage of it. If you enroll in Part B while you still have current employer coverage, your Medigap OEP will start, and unless you buy a Medigap policy before you need it, you'll miss your OEP entirely. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare.

If you aren't going to enroll in Part B due to current employment, it's important that you notify Social Security that you want to delay Part B.

NOTE: Remember, if you took Part B while you had employer coverage, you don't get another Medigap OEP when your employer coverage ends. You must have both Medicare Part A **and** Medicare Part B to buy a Medigap policy.

Pre-existing Conditions and Medigap

- Health problem you had before the new insurance policy starts
  - Treated or diagnosed 6 months before coverage start date
- Pre-existing Condition Waiting Period
  - Insurance companies can refuse to cover out-of-pocket costs for excluded condition for up to 6 months ("look-back period")
    - Without 6 months of prior creditable coverage and no break in coverage more than 63 days

The Affordable Care Act doesn't impact the pre-existing condition waiting period for Medigap coverage.

Medicare Supplement Insurance (Medigap) Policies

The insurance company may be able to make you wait for coverage related to a pre-existing condition (i.e. a health problem you have before the date a new insurance policy starts) for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

Coverage for a pre-existing condition can only be excluded in a Medigap policy if the condition was treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy. This is called the "look-back period." Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket costs. You're responsible for the Medicare coinsurance or copayment.

If you buy a Medigap policy during your Medigap Open Enrollment Period, and you're replacing certain kinds of health coverage that count as "creditable coverage" (generally any other health coverage you recently had before applying for a Medigap policy), it's possible to avoid or shorten this waiting period. If you had at least 6 months of continuous prior creditable coverage (with no break in coverage for more than 63 days), the Medigap insurance company can't make you wait before it covers your pre-existing conditions. You can learn more about creditable coverage by reviewing the Code of Federal Regulations, 45 CFR 146.113 at ecfr.gov/cgi-bin/ECFR?page=browse.

If you buy a Medigap policy when you have a guaranteed issue right, the insurance company can't use a pre-existing condition waiting period.

Medigap for People With a Disability or End-Stage Renal Disease (ESRD)

- People with a disability or ESRD may not be able to buy a policy until they turn 65
- Companies may voluntarily sell Medigap policies
  - May cost more than policies sold to people over 65
  - Can use medical underwriting
- Disabled Medicare beneficiaries under age 65 have equal access to all Medicare supplement policies sold in Kansas.
  - Supplement policies must be sold at the same rate as for seniors who turn 65 and are eligible for Medicare.
- Get a Medigap Open Enrollment Period at 65

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under 65 and eligible for Medicare coverage due solely to ESRD.

Some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can use medical underwriting. Check with your State Insurance Department about state-specific requirements and what rights you might have under state law.

Remember, if you're already enrolled in Medicare Part B, you'll get a Medigap Open Enrollment (OEP) Period when you turn 65. You'll probably have a wider choice of Medigap policies and be able to get a lower premium at that time. During your Medigap OEP, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare (Part A and/or Part B) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period.

Steps to Buy a Medigap Policy

STEP 1: Decide which benefits you want, then decide which of the standardized Medigap policies meets your needs

STEP 2: Find out which insurance companies sell Medigap policies in your state

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs

STEP 4: Buy the Medigap policy

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

STEP 1: Decide which benefits you want, and then decide which Medigap policy meets your needs. Think about your current and future health care needs when deciding which benefits you want, because you might not be able to switch Medigap policies later.

STEP 2: Find out which insurance companies sell Medigap policies in your state. Call your State Health Insurance Assistance Program. Ask if they have a Medigap rate comparison shopping guide for your state. This guide usually lists companies that sell Medigap policies in your state and their costs. Or, call your State Insurance Department or visit Medicare.gov/find-a-plan/questions/medigap-home.aspx. If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. A customer service representative will help you.

STEP 3: Call the insurance companies that sell the Medigap policies you're interested in and compare costs. Use the checklist in the "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," CMS Product No. 02110 (see link below), to help compare.

STEP 4: Buy the Medigap policy. Once you decide on the insurance company and the Medigap policy you want, you should apply. The insurance company must give you a clearly worded summary of your Medigap policy.

These steps are described in greater detail in the "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," CMS Product No. 02110 at Medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf.

Why Switch Medigap Policies?

- You might switch policies if you
  - Are paying for benefits you don't need
  - Need more benefits now
  - Want to change your insurance company
  - Find a cheaper policy
- If not in your Medigap Open Enrollment Period
  - You may pay more for the new policy
  - There might be medical underwriting
  - You could have a delay in coverage for a pre-existing condition

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

You may want to switch Medigap policies if you're paying for benefits you don't need, you need more benefits now, you want to change your insurance company, or you find a cheaper policy. If you bought your Medigap policy before you were 65 (because you have a disability), you get a Medigap Open Enrollment Period when you turn 65 if you're enrolled in Part B.

If you had your old policy for less than 6 months, the insurance company may be able to make you wait and delay coverage of a pre-existing condition for up to 6 months. If your old policy had the same benefits, and you had it for 6 months or more, the new insurance company can't exclude your pre-existing condition. If you had your policy less than 6 months, the number of months you had your current Medigap policy must be subtracted from the time you must wait before your new policy covers your pre-existing condition.

If the new Medigap policy has a benefit that isn't in your current policy, that benefit coverage may still be delayed up to 6 months, regardless of how long you've had your current Medigap policy.

If you've had your current Medigap policy longer than 6 months, and want to replace it with a new one with the same benefits, and the insurance company agrees to issue the new policy, they can't write pre-existing conditions, waiting periods, elimination periods, or probationary periods into the replacement policy.

When Can You Switch Medigap Policies?

- A right under federal law to switch only
  - During your Medigap Open Enrollment Period
  - If you have a guaranteed issue right
- If your state has more generous requirements
- Anytime insurance company will sell you one
- When you buy a new Medigap policy
  - You'll have a 30-day "free-look period"
    - You'll need to pay both Medigap policy premiums

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

In most cases you won't have a right under federal law to switch Medigap policies unless one of the following is true:

- You are within your Medigap Open Enrollment Period.
- You have a guaranteed issue right. This is a right you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a policy, or place conditions on a policy, such as exclusions for pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

If your state has more generous requirements, or the insurance company is willing to sell you a Medigap policy, make sure you compare benefits and premiums before switching. If you switch, you don't have to cancel your first Medigap policy until you've decided to keep the second policy. You have a 30-day "free-look" period to decide if you want to keep the new policy. It starts when you get your new policy. You have to pay both premiums for one month.

You can switch anytime an insurance company is willing to sell you a Medigap policy.

NOTE: If you move out of your Medicare SELECT policy's area, you can buy a standardized policy with the same or fewer benefits than your current plan, or buy Plan A, B, C, F, K, or L that's sold by any insurance company in your state or the state to which you're moving.

Medigap Guaranteed Issue Rights

- Federal protections in certain situations
  - Companies must sell you a Medigap policy
  - All pre-existing conditions must be covered
  - Can't be charged more
  - Must apply within 63 days of date other coverage ends

AD ASTRA

Guaranteed issue rights are federal protections you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions. It also can't charge you more for a Medigap policy because of a past or present health problem.

In many cases, you have a guaranteed issue right when you have other health coverage that changes in some way, such as when you lose or drop the other health care coverage. In other cases you have a "trial right" to try a Medicare Advantage Plan and still buy a Medigap policy if you change your mind. Some states have additional protections.

More detail about Guaranteed Issue Rights is contained at ssa.gov/OP_Home/ssact/title18/1882.htm (1882(s)(3)(A) of the Social Security Act).

Guaranteed Issue Rights Situations

This chart describes the situations under federal law that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issued rights.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
You're in a Medicare Advantage Plan (like an HMO or PPO), and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. **Note:** In this situation, you may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. Call the Medicare SELECT insurer for more information about your options.	Medigap Plan A, B, C, F, K, or L that's sold by any insurance company in your state or the state you're moving to.	As early as 60 calendar days before the date your Medicare SELECT coverage will end, but no later than 63 calendar days after your Medicare SELECT coverage ends.

Guaranteed Issue Rights Situations (continued)

This chart describes the situations under federal law that give you a right to buy a policy, the kind of policy you can buy, and when you can or must apply for it. States may provide additional Medigap guaranteed issued rights.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
(**Trial right**) You joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	Any Medigap policy that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
(**Trial right**) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medigap policy **isn't** available, you can buy Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.
You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C, F, K, or L that's sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.

Right to Suspend Medigap for People With Medicaid

- If you have both Medicare and Medicaid
  - You generally can't buy a Medigap policy
- You can suspend your Medigap policy
  - Within 90 days of getting Medicaid
    - For up to 2 years
- You can start it up again
  - No new medical underwriting or waiting periods

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

If you have both Medicare and Medicaid, most of your health care costs are covered. Medicaid is a joint federal and state program. Coverage varies from state to state. People with Medicaid may get coverage for things that aren't covered by Medicare, like some nursing home care and home health care.

If you already have Medicaid, an insurance company can't legally sell you a Medigap policy unless one of the following is true:

- Medicaid pays your Medigap premium
- Medicaid only pays all or part of your Medicare Part B premium

Remember, the insurance company may use medical underwriting, which could affect acceptance, cost, and the date of coverage.

There are a few things you should know if you have a Medigap policy and then become eligible for Medicaid:

- You can put your Medigap policy on hold (suspend it) within 90 days of getting Medicaid.
- You can suspend your Medigap policy for up to 2 years. However, you may choose to keep your Medigap policy active so you can see doctors who don't accept Medicaid, or if you no longer meet Medicaid spend-down requirements.
- At the end of the suspension, you can restart the Medigap policy without new medical underwriting or waiting periods for pre-existing conditions.

NOTE: If you suspend a Medigap policy you bought before January 2006 and it included prescription drug coverage, you can get the same Medigap policy back, but without the prescription drug coverage.

Right to Suspend Medigap

- If you suspend your Medigap policy
  - You don't pay Medigap premiums
  - The Medigap policy won't pay benefits
- You may not want to suspend your policy
  - To see doctors who don't accept Medicaid
- Call your state Medicaid office or State Health Insurance Assistance Program (SHIP) for help

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

There are advantages to suspending your Medigap policy rather than dropping it. If you put your Medigap policy on hold (suspend it), you won't have to pay your Medigap premiums while it's suspended. Keep in mind that your Medigap policy won't pay benefits while it's suspended.

You may suspend your Medigap policy if you get Medicaid. However, you may not want to do this if you want to see doctors who don't accept Medicaid.

Call your State Health Insurance Assistance Program (SHIP), (1-877-839-2675) or visit shiptacenter.org/ to help you with this decision.

For questions about suspending a Medigap policy, call your Medigap insurance company.

More detail about the right for people with Medicaid to suspend a Medigap policy is contained at ssa.gov/OP_Home/ssact/title18/1882.htm (1882(q) (5)(A) of the Social Security Act).

Right to Suspend Medigap for People Under 65

- Can suspend Medigap policy if under 65
  - While enrolled in your or your spouse's employer group health plan
- Get your Medigap policy back at any time
  - Must notify insurer within 90 days of losing employer plan
  - No waiting period

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

If you're under 65, have Medicare, and have a Medigap policy, you have a right to suspend your Medigap policy benefits and premiums without penalty while you're enrolled in your or your spouse's employer group health plan (EGHP). You can enjoy the benefits of your employer's insurance without giving up your ability to get your Medigap policy back when you lose your employer coverage. There's no limit to the amount of time that your policy can be suspended.

States may choose to offer this right to people over 65 as well. Check with your State Insurance Department.

If for any reason you lose your EGHP coverage, you can get your Medigap policy back. The following is true if you notify your Medigap insurance company that you want your Medigap policy back within 90 days of losing your EGHP coverage:

- Your Medigap benefits and premiums will start again on the day your EGHP coverage stops.
- The Medigap policy must have the same benefits and premiums it would've had if you'd never suspended your coverage.
- Your Medigap insurance company can't refuse to cover care for any pre-existing conditions you have.

More detail about the right to suspend a Medigap policy for people under 65 is contained in ssa.gov/OP_Home/ssact/title18/1882.htm (1882(q)(6) of the Social Security Act).

Key Points

- You must have both Medicare Part A and Part B to get a Medigap policy
- You still pay the Medicare Part B premium
- You pay a monthly premium for Medigap
- Medigap policies cover one person
- Benefits are standardized in most states
- Costs vary by plan and by company
- In general, can only cover costs associated with services covered by Original Medicare
- Medigap policies don't work with Medicare Advantage Plans

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

There are some key points you should know about Medigap.

- To buy a Medigap policy, you generally must have Medicare Part A and Part B.
- If you buy a Medigap policy, you must continue to pay your Medicare Part B premium. You pay the insurance company a monthly premium for your Medigap policy.
- Medigap policies only cover individuals. Your spouse wouldn't be covered by your policy. If your spouse wants Medigap coverage, he or she would have to purchase his or her own individual policy.
- Medigap insurance companies in most states can only sell you a standardized Medigap policy identified by letters A, B, C, D, F, G, K, L, M, and N. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it.
- The costs for a Medigap policy can vary by the plan you choose, and by the company from which it's purchased.
- In general, Medigap policies cover costs associated with services covered by Original Medicare.
- Medigap policies don't work with Medicare Advantage Plans.

Course Completion

- Thank you for completing this pre-training course!
- You have reviewed the following:
  - Medicare Prescription Drug Coverage under:
    - Medicare Part A
    - Medicare Part B
    - Medicare Part D
  - Medicare Advantage and Other Health Plans
  - Medicare Supplement Insurance (Medigap)
- You should now follow the instructions on the next page to complete the course exam.

AD ASTRA

Course Examination

- Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/
- Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 2 Exam.
- After successful completion of the Course 2 Exam, please continue to *Course 3 Introduction to Medicare Coordination, Protections, and More*.

AD ASTRA

Please log into the SHIP Technical Assistance Center, https://www.shiptacenter.org/

Use the Online Counselor Certification Tool, https://shipta.medicareinteractive.org/ship-certification-tool, to complete the SHICK Initial Pre-Training Course 2 Exam.

After successful completion of the Course 2 Exam, please continue to *Course 3 Introduction to Medicare Coordination, Protections, and More*.