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

Online Pre-Training

Rev. Feb. 2019

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 influenza virus vaccine (flu shot), a pneumococcal shot (to prevent certain types of pneumonia), a Hepatitis B shot (for individuals at high or intermediate risk), and other vaccines (like a tetanus shot) when you get it to treat an injury or if you've been exposed directly to a disease or condition.

Generally, Medicare drug plans (Part D) cover other vaccines (like the shingles vaccine) needed 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 be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment levels
  - Deductible
  - Coverage for drugs not typically covered by Part D
- 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

- Current or past prescription drug coverage
  - For example, employer group health plans, retiree plans, Veterans Affairs, TRICARE, the Indian Health Service, and the Federal Employee Health Benefits Program
- Creditable if it pays, on average, as much as Medicare's standard drug coverage
- Plans inform yearly about whether creditable
- With creditable coverage you may not have to pay a late enrollment penalty

Medicare Prescription Drug Coverage

ADASTRA

Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, Veterans Affairs, the Federal Employee Health Benefits Program, or the Indian Health Service. If you have other prescription drug coverage, you'll get information each year from your plan that tells you if the plan is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. We call this "creditable coverage." Your plan may send you this information in a letter or include it in its newsletter. Keep this information because you may need it if you join a Medicare drug plan later.

If you have this kind of coverage when you become eligible for Medicare, you can generally keep that coverage and 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) don't meet Medicare's minimum standards (it's not 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.

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 penalty.

When You Can Join or Switch Plans

- Medicare's Open Enrollment Period is October 15–December 7 each year, coverage starts January 1
- If you leave a Medicare Advantage Plan and switch to Original Medicare from January 1–March 31 each year during the Medicare Advantage Open Enrollment Period
  - You also get a special enrollment period to join a Medicare Prescription Drug Plan
- If you don't have Medicare Part A coverage, and enroll in Part B during the General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30 each year

Medicare Prescription Drug Coverage

AD ASTRA

- Medicare's Open Enrollment Period runs from October 15–December 7 each year, with changes going into effect on January 1.
- January 1–March 31 Medicare Advantage Open Enrollment Period
  - If you are in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch, you have a special enrollment period to join a Medicare Prescription Drug Plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.
- April 1–June 30 (limited)
  - If you don't have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30. Your coverage begins 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.

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

Medicare Prescription Drug Coverage

Plans are assigned their star rating once a year, in October, for the upcoming 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 Special Enrollment Period (SEP). The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

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.

At any time during the year, you can use the 5-star 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.

CMS also created a coordinating SEP for Medicare Prescription Drug Plans. 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 between December 8 and November 30 of the following 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 first day of the month following the month in which the plan gets your enrollment request.

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 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.

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

Medicare Prescription Drug Coverage

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A contract 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 2015, 2016, and 2017 plan ratings for Part C or Part D) will be marked with the above icon on Medicare Plan Finder. Medicare sends the "Introduction to the Consistent Poor Performer," CMS Product Number 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 http://www.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 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. Includes 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 considered safer and clinically recommended for their condition.

This information is gathered from several different sources. In some cases it's based on member surveys. In other cases, it's based on reviews of billing and other information that 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 ($33.19 in 2019)
    - 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 ($33.19 in 2019) 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, 2016
- Has no drug coverage from any other source
- Joined a Medicare drug plan during the 2018 Open Enrollment Period
  - Her coverage begins on January 1, 2019
- Without creditable prescription drug coverage from June 2016–December 2018
- The penalty in 2019 is 31% (1% for each of the 31 months) of $33.19 (the national base beneficiary premium for 2019), which is $10.29
- The monthly penalty is rounded to the nearest $.10, so she'll be charged $10.30 each month in addition to her plan's monthly premium in 2019

Here's the math:

.31 (31% penalty) × $33.19 (2019 base beneficiary premium) = $10.29

$10.29 (rounded to the nearest $0.10) = $10.30

$10.30 = Ann's monthly late enrollment penalty for 2019

Medicare Prescription Drug Coverage

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Ann didn't join when she was first eligible—by May 31, 2016. She doesn't have drug coverage from any other source. She joined a Medicare drug plan during the 2018 Open Enrollment Period. Her coverage will begin on January 1, 2019.

She was without creditable prescription drug coverage from June 2016–December 2018. Her penalty in 2019 is 31% (1% for each of the 31 months) of $33.19 (the national base beneficiary premium for 2019), which is $10.29. The monthly penalty is rounded to the nearest $.10, so she'll be charged $10.30 each month in addition to her plan's monthly premium in 2019.

Here's the math:

- **.31** (30% penalty) × **$33.19** (2019 base beneficiary premium) = **$10.29**
- **$10.29** (rounded to the nearest $0.10) = **$10.30**
- **$10.30** = **Ann's monthly late enrollment penalty for 2019**

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 2019, most people will pay
  - A monthly premium
  - A yearly deductible (if applicable)
  - Copayments or coinsurance
  - 25% for covered brand-name drugs in the coverage gap
  - 37% for covered generic drugs in the coverage gap
  - Very little after spending $5,000 out of pocket

Medicare Prescription Drug Coverage

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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. Extra Help is discussed in more detail in Lesson 5.

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.

Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. 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. You may also see a delay in premiums being withheld if you switch plans. If you want to stop premium deductions and get billed directly, contact your drug plan.

When you are in the coverage gap, you pay no more than 25% for covered brand-name drugs, and 37% for covered generic drugs.

With every plan, once you've paid $5,000 out-of-pocket for drug costs in 2019 (including payments from other sources, like the discount paid for by the drug company in the coverage gap), you leave the coverage gap and pay a small copayment for each drug for the rest of the year.

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 $415 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 $3,820 (Initial Coverage Limit).	Once Ms. Smith and her plan have spent $3,820 for covered drugs, she's in the coverage gap. In 2019, 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 2019, she gets an additional 5% coverage from her plan on covered brand-name drugs and 63% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent $5,100 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 $415 in 2019)—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 $415 in 2019. 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 ($3,820 in 2019). In 2019, once you enter the coverage gap, you pay 25% of the plan's cost for your covered brand-name drugs and 37% of the plan's cost for covered generic 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 ($5,100 in 2019), you leave the coverage gap, and automatically get catastrophic coverage, where you only pay a small coinsurance or copayment 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
2018	35%	44%
2019	25%	37%
2020	25%	25%

Medicare Prescription Drug Coverage

Once you reach the coverage gap in 2019, you'll pay 25% of the plan's cost for covered brand-name 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 2019, 95% of the price—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 aren't counted toward your out-of-pocket spending.

In 2019, Medicare will pay 66% of the price for generic drugs during the coverage gap. You'll pay the remaining 37% of the price. What you pay for generic drugs during the coverage gap will decrease each year until it reaches 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

If you have a Medicare drug plan that already includes coverage in the gap, you may get a discount after your plan's coverage has been applied to the price of the drug. The discount for brand-name drugs will apply to the remaining amount that you owe.

True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($5,100 in 2019)
- 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 $5,100 (for 2019). 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)

AD ASTRA

Payments that count toward your True out-of-pocket costs include those made for covered prescriptions:

- Before your drug plan begins to pay (annual deductible, if there is one)
- After your drug plan begins to pay (copayments or coinsurance during your initial coverage period)
- During your coverage gap, if the plan has a coverage gap

Payments count toward TrOOP if they're made by any of these:

- 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 manufacturers providing discounts under the Medicare coverage gap discount program
- AIDS Drug Assistance Programs (ADAPs)

Certain conditions must be met for a payment to count toward TrOOP. Payments must be for drugs that are on the plan's formulary or those drugs treated as being on the formulary because of a coverage determination, exceptions process, or an appeal. The drugs must be purchased in a network pharmacy or the drugs must be purchased at an out-of-network pharmacy in accordance with the plan's out-of-network policy.

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
- 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

AD ASTRA

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 2017			In 2019 You Pay
Filing an Individual Tax Return	Filing a Joint Tax Return	File married & separate tax return	
$85,000 or less	$170,000 or less	$85,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	not applicable	YPP + $12.40*
Above $107,000 Up to $133,500	Above $214,000 Up to $267,000	not applicable	YPP + $31.90*
Above $133,500 Up to $160,000	Above $267,000 Up to $320,000	not applicable	YPP + $51.40*
Above $160,000 and less than $500,000	Above $320,000 and less than &750,000	Above $85,000 and less than $415,000	YPP + $70.90*
$500,000 and above	$750,000 and above	$415,000 and above	YPP + $77.40*

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

Medicare Prescription Drug Coverage

You pay only your plan premium if your yearly income in 2017 was $85,000 or less for an individual, or $170,000 or less for a couple.

If you reported a modified adjusted gross income of more than $85,000 (individuals and married individuals filing separately) or $170,000 (married individuals filing jointly) on your Internal Revenue Service (IRS) tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount (IRMAA). You pay this extra amount in addition to your monthly Medicare drug plan premium.

If your income has gone down due to any of the following situations, and the change makes a difference in the income level Social Security considers, contact them to explain you have new information and may need a new decision about your IRMAA:

- You married, divorced, or became widowed
- You or your spouse stopped working or reduced your work hours
- You or your spouse lost income-producing property due to a disaster or other event beyond your control
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan
- You or your spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

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
  - Cancer medications
  - HIV/AIDS treatments
  - Antidepressants
  - Antipsychotic medications
  - Anticonvulsive treatments
  - Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)
- Most compounded medications

Medicare Prescription Drug Coverage

AD ASTRA

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

1. Cancer medications
2. HIV/AIDS treatments
3. Antidepressants
4. Antipsychotic medications
5. Anticonvulsive treatments for epilepsy and other conditions
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), and most compounded medications (as defined in the Code of Federal Regulations' Access to covered Part D drugs, *§423.120(d)),* ecfr.gov/cgi-bin/text-idx?SID=7805cfe316ca233ff673e2e02b0e6b74&mc=true&node=se42.3.423_1120&rgn=div8. You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

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
    - Such as replacing brand-name drug with new generic
- Plans usually notify you 60 days before changes
  - You may be able to continue to have your drug covered until end of calendar year
  - May ask for exception if other drugs don't work
- Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification

Medicare Prescription Drug Coverage

AD ASTRA

A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. It's also called a drug list. 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 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. Those changes must be made according to the prescribed approval procedures, and plans must give 60 days' notice to CMS, State Pharmacy Assistance Programs, prescribing doctors, network pharmacies, pharmacists, and people covered under the plan. 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 removed from the formulary due to a U.S. Food and Drug Administration (FDA) decision 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 60 days' notice.

Request a Part D Coverage Determination

- A coverage determination is the initial decision made by a 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 request
  - 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/.

When Plans Must Grant Formulary Exceptions

- Plan must grant a formulary exception if
  - All formulary alternatives aren't as effective and/or
  - Drug would have adverse effects
- Plan must grant an exception to a coverage rule
  - If coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or
  - It has caused, or is likely to cause, harm to enrollee

Medicare Rights and Protections

AD ASTRA

A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or the drug would have an adverse effect. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused, or is likely to cause, harm to the enrollee.

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

Enhanced Drug Utilization Review	▪ If you use high amounts of opioids from several doctors and pharmacies, your plan may communicate with your doctor(s) to understand if some or no opioid medications are appropriate and medically necessary ▪ You'll get a letter 30 days in advance if you'll be limited to some or no opioid medications ▪ If you believe this is a mistake, you or your doctor may contact the plan to request a coverage determination
Opioid Safety Edits	▪ An alert triggers at the pharmacy if your recent prescription(s) exceeds a high amount of opioids ("morphine equivalent dose") ▪ Some alerts can be overridden by the pharmacist while others may require a decision by the plan to override ▪ If your pharmacy can't fill a prescription, the pharmacist will issue a notice explaining that you can contact the plan to request a coverage determination

Medicare Prescription Drug Coverage

AD ASTRA

Medicare drug plans also monitor the safe and effective use of prescription drugs including opioids.

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 such as addiction, overdose, and death.

If you use high amounts of opioids from several doctors and pharmacies (and you don't have cancer and you're not in hospice), your plan may communicate with the doctor(s) who prescribed your opioid medication(s). After speaking with your doctor(s), some or no opioid medications may be found to be appropriate and medically necessary. You'll get a letter 30 days in advance before you'll be limited to some or no opioid medications. If you believe a mistake has been made, you and your prescriber have the right to request a coverage determination by contacting the plan.

In addition, plans may put in place safety alerts that could trigger when you fill a prescription at the pharmacy if your recent prescription(s) exceed a high, total amount of opioids (also referred to as a "cumulative morphine equivalent dose" (MED)). Some alerts can be overridden by the pharmacist while others may require a decision by the plan to override. If your pharmacy can't fill a prescription, the pharmacist will give you a notice explaining that you can contact the plan to request a coverage determination.

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.

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.

Steps to Choosing a Medicare Drug Plan

1. Prepare
2. Compare plans on the Medicare Plan Finder
3. Decide and enroll

AD ASTRA

On the next pages we'll show you 3 steps to choosing a Medicare drug plan:

1. Prepare
2. Compare plans on the Medicare Plan Finder
3. Decide and enroll

Step 1: Prepare

- Prepare by getting your information together
  - Current prescription drug coverage
  - Prescription drugs, dosages, and quantities
  - Preferred pharmacies
  - Medicare card
  - ZIP code

Medicare Prescription Drug Coverage

AD ASTRA

Step 1: Before choosing a Medicare drug plan, you may want to get your information together. You need information about any prescription drug coverage you may currently have, as well as a list of the prescription drugs and doses you currently take. You'll also need the names of any pharmacies you prefer to use, your Medicare card, and your ZIP code. Finally, gather any notices you get from Medicare, Social Security, or your current Medicare drug plan about changes to your plan.

NOTE: For a helpful Medicare Plan Finder worksheet, visit CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/Medicare-Plan-Finder-Worksheet.pdf.

Step 2: Compare Plans on Medicare Plan Finder

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on star ratings, benefits, costs, and more

Medicare Prescription Drug Coverage

Step 2: Visit Medicare.gov/find-a-plan and use the Medicare Plan Finder to:

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more

You should compare Medicare drug plans based on what's most important to your situation and your drug needs. You may want to ask yourself these questions:

- Which plan(s) covers the prescriptions I take?
- Which plan(s) gives me the best overall price on all of my prescriptions?
- What's the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Which plan(s) allows me to use the pharmacy I want or get prescriptions through the mail?
- Which plan(s) gives me coverage in multiple states, if I need it?
- What star ratings did the plan(s) get?
- Can my coverage start when I want it to?
- Is it likely that I'll need protection against unexpected drug costs in the future?

Step 3: Decide and Join

- 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

Step 3: After you pick a plan that meets your needs, call the company offering it, and ask how to join. You may be able to join online, by phone, or by paper application. You'll have to give the number on your Medicare card when you join.

You can join 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, 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 these steps and worksheets to help with this process in "Your Guide to Medicare Prescription Drug Coverage," CMS Product No. 11109, which you can find 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, 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 by September 30
  - May be sent with Evidence of Coverage (EOC)
- 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 by September 30, along with a summary of benefits 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 no later than January 31 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. The plan may choose to send the EOC with the ANOC.

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 prescription drug costs
  - Also called the Low-income Subsidy
- 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
- No coverage gap or late enrollment penalty if you qualify
- LIS Special Enrollment Period

Medicare Prescription Drug Coverage

AD ASTRA

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. Extra Help is also called the Low-income Subsidy (LIS).

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 have a coverage gap or late enrollment penalty. You'll 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.

To find your level of Extra Help, visit Medicare.gov/your-medicare-costs/help-paying-costs/extra-help/level-of-extra-help.html.

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.

2019 Extra Help
Income and Resource Limits

- Income limits
  - Below 150% of the federal poverty level
    - $18,735* per year for an individual, or $25,365* per year for a married couple
  - Based on family size
- Resources limits
  - Up to $14,390* per year for an individual, or $28,720* 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 2019. 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 2019 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.

2019 Extra Help Copayments

Extra Help Copayments	2019 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)	$1.25/$3.80
Full Extra Help (Level 1)	$3.40/$8.50
Partial Extra Help (Deductible/Cost-Sharing) (Level 4)	$85.00/15%

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 $1.25 for a generic drug (or brand-name drug treated as a generic), or $3.80 for brand-name covered prescriptions
- If your income is between 100% and 135% of the FPL, you pay either $3.40 for a generic drug (or brand-name drug treated as a generic), or $8.50 for brand-name covered prescriptions
- If you get Partial Extra Help, you pay a $85 deductible in 2018 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.

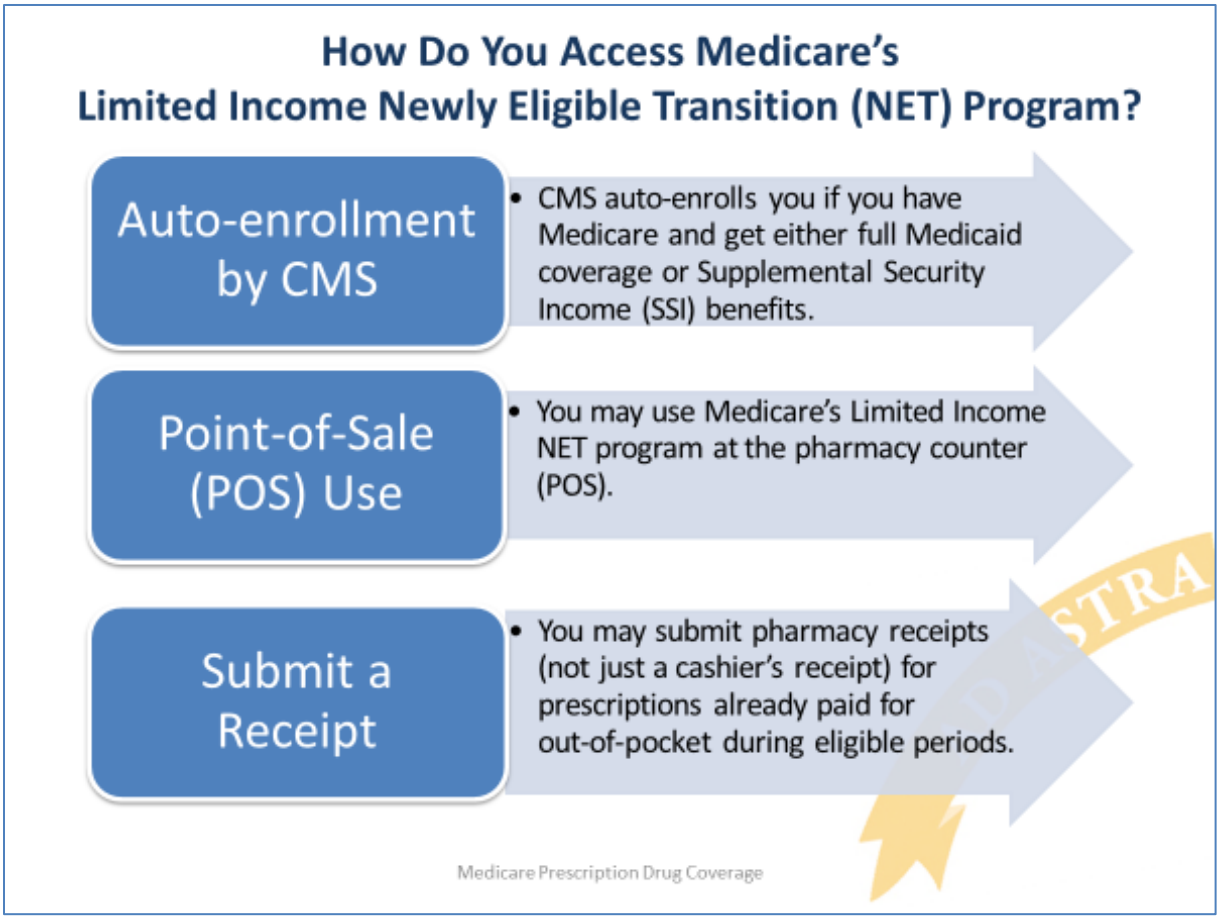
Enrollment in Medicare's Limited Income NET program is temporary and ends once a low-income person with Medicare gets coverage through a Medicare drug plan. The program gives point-of-sale coverage to people with Extra Help who don't yet have a Medicare drug plan. It also gives retroactive coverage to 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 Health Insurance Claim 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, the Centers for Medicare & Medicaid Services (CMS) will reassign certain people who qualify for Extra Help into new Medicare Prescription Drug Plans 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, 2016. These people will be reassigned into a new Medicare Prescription Drug Plan 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 Prescription Drug Plan (PDP) is leaving the Medicare Program that they'll be reassigned to a new PDP if they don't join a plan on their own by December 31, 2016.
- CMS Product No. 11443—informs people who qualify for Extra Help and whose Medicare Advantage Plan is leaving the Medicare Program that they'll be enrolled in a Medicare PDP if they don't join a new plan on their own by December 31, 2016.

A third version is for people whose premiums are increasing above the regional low-income premium subsidy amount (CMS Product No. 11209). The notice tells people which plan they'll be reassigned to, explains how to stay in their current Medicare drug plan if 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 their 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, 2016, Medicare will reassign them into a new plan with coverage effective January 1, 2017.

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.

What are 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.

How do Medicare Advantage Plans work?

- Medicare pays the plan every month for your care
  - Provides Medicare-covered benefits
  - You still have Medicare rights and protections
- You may have to use in-network doctors/ hospitals
- May differ from Original Medicare—cost sharing
- If the plan leaves Medicare, you can
  - Join another MA Plan, or
  - Return to Original Medicare

Medicare Advantage and Other Health Plans

AD ASTRA

- It's important to note that when you join a Medicare Advantage (MA) Plan or other Medicare health plan
  - You're still in the Medicare Program. Medicare pays these private health plans for your care every month, whether you use services or not.
  - You still have Medicare rights and protections.
- In some plans, like Medicare Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals. You save the most money out-of-pocket when you get services through the plan's network.
- Cost sharing in an MA Plan may differ from Original Medicare.
- If the plan decides to stop participating in Medicare, you will have the opportunity to join another MA Plan or return to Original Medicare.

Medicare Advantage Plan Costs

- You still pay the monthly Part B premium
  - A few plans may pay all or part for you
  - State assistance is available for some
- You may pay an additional monthly premium to the plan
- Plan deductibles, coinsurance, and copayments
  - Different from Original Medicare
  - Vary from plan to plan
  - May be higher if out-of-network

Medicare Advantage and Other Health Plans

AD ASTRA

- If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. For most people, the monthly Part B premium in 2019 is between $130 and $135.50.
  - A few plans may pay all or part of the Part B premium for you.
  - Some people may be eligible for state assistance (programs for people with Medicare who have limited income and resources).
- When you join an MA Plan there are other costs you may have to pay, like
  - An additional monthly premium to the plan
  - Deductibles, coinsurance, and copayments (required by most plans). These costs may
    - Be different from Original Medicare
    - Vary from plan to plan
    - Be higher if you go out of the plan's network

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

Medicare Advantage and Other Health Plans

AD ASTRA

People with End-Stage Renal Disease (ESRD) usually can't join a Medicare Advantage (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 (i.e., 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 an employer group health plan may be allowed to enroll in an MA Plan offered by the same plan parent organization, provided 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 if:

- 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 a Health Maintenance Organization (HMO) to a Preferred Provider Organization (PPO) or a Private-Fee-for-Service (PFFS) Plan within the same parent organization, if 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.

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 a continuous (SEP) 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 have a continuous (SEP), meaning you can enroll in or switch your plan at any time, if you qualify for Extra Help (a program that helps people with limited income and resources).
- You lose your Extra Help status.
- You receive notice of retroactive Medicare entitlement.
- Other exceptional circumstances.

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4, at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf.

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

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Medicare Advantage and Other Health Plans

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.

When You Join or Switch Medicare Advantage (MA) Plans

Medicare Advantage Open Enrollment Period (MA-OEP)	▪ January 1 – March 31 • Allows individuals enrolled in an MA plan to make a one-time election to go to another MA plan or Original Medicare.* • Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. • If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare.

Important: If the beneficiary disenrolls from a Medicare private health plan (Medicare Advantage), federal law does not give the beneficiary the right of guarantee issue to buy a Medigap plan.

Medicare Advantage and Other Health Plans

If you belong to a Medicare Advantage (MA) Plan or Medicare Advantage with Prescription Drug (MA-PD) Plan, you may make a one-time election to switch to another MA plan or return to Original Medicare from January 1 through March 31. If you make a change during this time, plan coverage will take effect on the first day of the calendar month following the date the election or change was made.

If you leave an MA Plan, you may or may not be able to buy a Medicare Supplement Insurance (Medigap) policy. It depends on your individual circumstances. Certain federal rights may apply. States may provide additional protections. You can buy a Medigap policy any time a plan will sell you one. See next page for more information.

If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare. Coverage begins the first day of the month after the plan gets the enrollment form.

It's important to remember that anytime you enroll in a new MA, MA-PD, or Medicare Prescription Drug Plan, it will automatically disenroll you from your previous plan. This includes MA-only Health Maintenance Organization and Preferred Provider Organization Plans. However, there are limited exceptions for members of MA-only Private Fee-for-Service, Cost and Medicare Medical Savings Account Plans. Once enrolled, coverage begins the first day of the month after the plan gets the enrollment form.

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

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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 plan with a bank account
- Medicare deposits money into account
  - Use money to pay for health care services
  - No cost sharing once the deductible has been paid

Medicare Advantage and Other Health Plans

AD ASTRA

There are other, less common types of Medicare Advantage Plans, like Medical Savings Account (MSA) Plans—a plan that combines 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.

For more information about MSA Plans, visit Medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-savings-accounts/medical-savings-account-plans.html. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

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.

Other Medicare Health Plans

- Other types of Medicare health plans that provide health care coverage aren't part of Medicare Advantage
  - But are still part of Medicare
  - Some provide Part A and/or Part B coverage
  - Some provide Medicare prescription drug coverage

Medicare Advantage and Other Health Plans

AD ASTRA

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans, but are still part of Medicare. Some of these plans provide

- Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage
- Some provide Medicare prescription drug coverage (Part D)

These plans have some of the same rules as MA Plans. Some of these rules are explained briefly on the next few slides. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Innovation Projects and Pilot Programs

- Special projects that test improvements in
  - Medicare coverage
  - Payment
  - Quality of care
- Eligibility usually limited
  - Specific group of people or specific area of country
- Examples of how they help shape Medicare
  - Medicare Advantage (MA) Plan for End-Stage Renal Disease (ESRD) patients
  - New Medicare preventive services

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare innovation projects and pilot programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They're usually for a specific group of people and/or are offered only in specific areas. Some follow Medicare Advantage (MA) Plan rules, but others don't. The results of innovation projects have helped shape many of the changes in Medicare over the years, including

- Development of an MA Plan design for End-Stage Renal Disease patients
- New Medicare preventive services

Check with the innovation project or pilot program for more information about how it works. To find more information, visit CMS.gov/medicare/demonstration-projects/demoprojectsevalrpts/index.html, Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

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

- The Centers for Medicare and Medicaid Services (CMS) requires review and approval of certain materials
  - Exceptions are listed in Section 20 of the Medicare Marketing Guidelines.
    - For more information visit https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf
  - Plans must maintain materials and make them available at CMS's request
- CMS creates standardized and model marketing materials

Medicare Advantage and Other Health Plans

AD ASTRA

- CMS reviews marketing materials, with the exception of those in Section 20 of the Medicare Marketing Guidelines (MMG). 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 MMG
- 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 Advantage organizations and Prescription Drug Plan Sponsors 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 materials, such as the provider and pharmacy directories.

For more information visit https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf and, also see the resources slide at the end of this presentation for the link to the MMG.

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

- Medicare Advantage and Prescription Drug Plans must disclose plan information
  - At time of enrollment and at least annually
    - Required Annual Notice of Change/Evidence of Coverage
    - Low Income Subsidy (LIS) rider
    - Comprehensive or abridged formulary
    - Member ID card at the time of enrollment/as needed
- Must provide the hard copy pharmacy and provider directories or a notice describing where they can be found online together with how to request a hardcopy
- Documents for new enrollees must be provided no later than 10 calendar days or the last day of the month before to effective date, whichever is later

Medicare Advantage and Other Health Plans

To ensure that enrollees receive comprehensive plan information regarding their health care options, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage and Prescription Drug Plan (PDP) organizations to disclose certain plan information both at the time of enrollment and at least annually, 15 days before the Open Enrollment Period.

- This requirement includes the annual dissemination of the following that members must get no later than September 30 each year:
  - Standardized Annual Notice of Change and Evidence of Coverage as applicable.
  - Low Income Subsidy (LIS) rider. This comes from the plan if someone qualifies for Extra Help and tells them how much help they'll get next year with their drug plan premium, deductible, and copayments.
  - Comprehensive formulary or abridged formulary including information on how the beneficiary can obtain a complete formulary (Part D sponsors only).
  - Membership identification card (required only at the time of enrollment and as needed or required by plan sponsor post-enrollment).
- Must provide the hard copy directories for the following, or a notice describing where they can be found online together with how to request a hard copy.
  - Pharmacy directory (for all plan sponsors offering a Part D benefit).
  - Provider directory (for all plan types except PDPs).
  - Organizations 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 to the effective date, whichever is later.

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.

Marketing in Health Care Settings

- Marketing allowed in health care common areas
  - Hospital or nursing home cafeterias
  - Community or recreational rooms
  - Conference rooms
- No marketing in health care settings where patients get care
  - Waiting rooms
  - Exam rooms and hospital patient rooms
  - Dialysis centers and pharmacy counter areas

Medicare Advantage and Other Health Plans

AD ASTRA

Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreation rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plans may not conduct sales presentations and distribute and accept enrollment applications in areas where patients primarily get health care services. These restricted areas generally include, but aren't limited to: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

Plans may schedule an appointment with someone living in long-term care facility only when the person with Medicare requests an appointment.

Additionally, providers may make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships.

Promotional Activity Reminders

- Prospective enrollees may not
  - Be provided meals
  - Have meals subsidized
- At any event or meeting where
  - Plan benefits are being discussed, or
  - Plan materials are being distributed

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare Advantage (MA) and Medicare Prescription Drug (PDP) Plan organizations 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 guidance, it's the responsibility of MA and PDP organizations to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities the Centers for Medicare & Medicaid Services (CMS) conducts will verify that plans and agents are complying with this provision, and CMS will take enforcement actions.

Educational Event Reminders

- Educational events for prospective members
- No marketing activities at educational events
- Plans may distribute
  - Medicare and/or health educational materials
  - Agent/broker business cards
  - Distributed material must not contain marketing information

Medicare Advantage and Other Health Plans

AD ASTRA

The plan or outside entities may sponsor educational events that are promoted to be educational in nature. Plans may distribute items related to education about the Medicare Program and general health and wellness. Agents and brokers may distribute their business cards if a person with Medicare requests one. Anything agents and brokers distribute may not have plan marketing information on or attached to the item(s).

Educational events for prospective members may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. The Centers for Medicare & Medicaid Services has clarified that the purpose of educational events is to provide objective information about the Medicare Program and/or health improvement and wellness. As such, educational events shouldn't be used to steer or attempt to steer a beneficiary toward a specific plan or plans. Plan sponsors or their representatives may not

- Discuss plan-specific premiums and/or benefits
- Distribute scope of appointment forms, enrollment forms, or sign-up sheets
- Set up individual sales appointments or get permission for an outbound call to the beneficiary
- Advertise an educational event and have a marketing/sales event immediately following in the same general location (e.g., at the same hotel)

The prohibited items mentioned may be distributed at a sales event. A sales event is an event sponsored by a plan or another entity with the purpose of marketing to potential members and steering, or attempting to steer, potential members toward a plan or plans.

Licensure and Appointment of Agents

- Medicare Advantage and Prescription Drug Plan organization 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

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare Advantage (MA) organizations and Medicare Prescription Drug Plan (PDP) sponsors that conduct marketing through agents, brokers, and other marketing representatives must comply with state licensure and appointment laws.

MA and PDP sponsors must comply with state appointment laws that require plans to give the state information about which agents are marketing the Part C and Part D plans.

Some plan activities, typically carried out by the plan sponsor'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.

Reporting of Terminated Agents

- Organizations must report termination of agents/brokers to
  - State(s), per state law
  - CMS Account Manager—for-cause terminations

Medicare Advantage and Other Health Plans

AD ASTRA

Medicare Advantage Organizations and Part D sponsors 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 Compensation Rules

- The Centers for Medicare & Medicaid Services' (CMS's) compensation rules
  - CMS sets limits on how much independent agents/brokers can be paid for enrollments
  - Designed to eliminate inappropriate enrollment moves from plan to plan
    - Also called "churning"

Medicare Advantage and Other Health Plans

AD ASTRA

The Centers for Medicare & Medicaid Services' compensation rules are for Medicare Advantage Plans and Medicare Prescription Drug Plans that use independent agents/brokers. The rules are designed to eliminate incentives that encouraged inappropriate enrollment moves from plan to plan (also called "churning").

Agent/Broker Compensation

- Two types of compensation
  - Initial—for people new to Medicare or who make an "unlike plan" change (e.g., Medicare Advantage with Prescription Drug [MA-PD] to Original Medicare with a Prescription Drug Plan)
  - Renewal—begins second year in a plan and for like plan changes (MA-PD to a different MA-PD)
- Agents can only be paid for the number of months an enrollee is in the plan

Medicare Advantage and Other Health Plans

ADASTRA

CMS permits 2 types of compensation—an initial and a renewal.

- Initial compensation is for people who age into Medicare and select a health plan; those whose previous enrollment was Original Medicare; and those who make an "unlike plan" change.
  - "Unlike plan" changes include the following:
    - A Medicare Advantage (MA) or Medicare Advantage with Prescription Drug (MA-PD) Plan to Original Medicare with a PDP or Section 1876 Cost Plan
    - A PDP to a Section 1876 Cost plan, an MA Plan, or MA-PD Plan
    - A Section 1876 Cost Plan to an MA Plan, MA-PD Plan, or PDP
- Renewal compensation is paid for each enrollment in year 2 and beyond in the same plan, or when "like plan" changes are made.
  - "Like plan" changes include the following:
    - A PDP to another PDP
    - An MA or MA-PD Plan to another MA or MA-PD Plan
    - A Section 1876 Cost plan to another Section 1876 Cost plan

Agents can only be paid for the number of months a member is enrolled in the plan. So, if a member enrolls in January and disenrolls in May, the agent may only be paid 5 months of the yearly compensation amount.

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

- CFR 422.134 expands rewards and incentive programs
- Applies to Medicare Advantage Organizations only
- Focus on encouraging participation in activities that promote
  - Improved health
  - Prevention of injuries and illness
  - Efficient use of health care resources

Medicare Advantage and Other Health Plans

AD ASTRA

The Centers for Medicare & Medicaid Services has expanded reward and incentive program options for Medicare Advantage Organizations (MAOs) through CFR 422.134. MAOs are now permitted to offer health-driven reward and incentive programs that may be applied to health-related services and activities. Before 4159-F, rewards and incentives were only allowed to be offered with preventive services. Now, an MAO may create one or more program(s) that provide rewards and incentives to enrollees who participate in any activities that focus on promoting improved health, preventing injuries and illness, and efficiently using health care resources.

- Each unique rewards and incentives program offered by an MAO must
  - Not discriminate against enrollees based on race, gender, chronic disease, institutionalization, frailty, health status, or other impairments
  - Be designed so that all enrollees are able to earn rewards
  - Be subject to sanctions at 42 CFR§422.752(a)(4)
  - Be offered in connection with the entire service or activity
  - Be offered to all eligible members without discrimination
  - Have a value that may be expected to affect enrollee behavior but not exceed the value of the health-related service or activity itself
  - Otherwise comply with all relevant fraud and abuse laws, including, when applicable, the anti-kickback statute and civil money penalty prohibiting inducements to people with Medicare
  - MAOs are required to abide by certain restrictions. This means the rewards and incentives program may not be
  - Offered in the form of cash or other monetary rebates, or
    - Used to target potential enrollees
    - At this time, rewards and incentives only apply to Part C.

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

- Standardized plans identified by a letter
  - Plans A, B, C, D, F, G, K, L, M, and N are currently sold
  - Companies don't have to sell all plans
  - Plans E, H, I, and J exist but are no longer sold
  - Plans with the same letter must offer the same basic benefits
    - Only the policy cost will vary between companies
- Waiver states (Massachusetts, Minnesota, and Wisconsin) standardize in a different way

Medicare Supplement Insurance (Medigap) Policies

AD ASTRA

In most states, Medigap insurance companies can only sell you a standardized Medigap policy identified by letters A, B, C, D, F, G, K, L, M, and N. Plans D and G with an effective date on or after June 1, 2010, have different benefits than Plans D and G bought before June 1, 2010. Plans E, H, I, and J are no longer sold, but, if you already have one, you can generally keep it. Plan F has a high-deductible option.

Each standardized Medigap plan must offer the same basic benefits, no matter which insurance company sells it. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from. Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies. You're encouraged to shop carefully for a Medigap policy.

Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap plan, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies may be available in your state. If you need more information, call your State Insurance Department or State Health Insurance Assistance Program. You can find their contact information at Medicare.gov/contacts/.

Some people may still have a Medigap policy they purchased before the plans were standardized. If they do, they can keep these plans. If they drop them, they may not be able to get them back.

Medigap policies are standardized in a different way in Massachusetts, Minnesota, and Wisconsin. These are called waiver states.

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 2018**							$5,560	$2,780		

*Plan F is 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 $2,300 in 2019 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 ($185 in 2019), 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. Plan F also offers a high-deductible plan, $2,300 in 2019, in some states.
- 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 2019, Plans K and L have out-of-pocket limits of $5,560 and $2,780, respectively.

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.

Medigap Costs

- Cost (monthly premium) depends on
  - Your age (in some states)
  - Where you live (e.g., urban, rural, or ZIP Code)
  - Company selling the policy
  - Discounts (women, non-smokers, married couples)
  - Medical underwriting
    - 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
- Premiums may vary greatly for same Medigap plan
- Medicare SELECT policies generally have lower premiums

Medicare Supplement Insurance (Medigap) Policies

There can be big differences in the premiums that different insurance companies charge for exactly the same coverage. Costs depend on your age (in some states), where you live (e.g., urban, rural, or ZIP Code), and the company selling the policy. The cost of your Medigap policy may also depend on whether the insurance company does any of the following:

- Offers discounts (such as 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).
- 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 slides 33-35), or aren't in your Medigap Open Enrollment Period.
- Sells Medicare SELECT policies that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be less.
- Offers a high-deductible option for Medigap Plan F.

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

Medicare Supplement Insurance (Medigap) Policies

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

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.

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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*.

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