Medicare 101

Medicare Supplements (MEDIGAP)
Medicare Advantage (MA / MAPD)
Prescription Drug Plans (PDP)

Updated August 2023

Compiled by Shelli Young-Wiseman

Insurance Specialties
7505 State Hwy 37
Purdy, MO 65734
800-789-0182

August 2023

In the years I have worked with agents in the Senior Market, I have continuously been asked, ***"Is there one place I can go to find answers to my questions about Medicare products?"*** Having never found such a resource, and after having our office team ask the same question, I decided to put together a definitive reference guide. A guide that you will want to keep readily available for reference when faced with specific client situations.

"Medicare 101" is the result of this effort. I designed this to help answer questions and show examples and scenarios that arise in day-to-day conversations with clients. It will take you from what happens when a client becomes Medicare-eligible though the best options to meet each client's unique needs. It is my hope this will enable you to find enrollment parameters to best cover your client's needs, while keeping you CMS Compliant. *

This guide works best in answering a question or addressing a problem if you START at the INDEX. By using the CTRL key and your mouse on a subject, you will be able to jump directly to the page. The Index lists the Topic, the Question, SEP Codes, or the Scenario you are working with, and then references to a page for details. It is divided into the following 6 sections:

1. Medicare Basic Overview (including Quick Reference Sheet on Medicare Costs for 2020)
2. Part C & D (MA/MAPD/PDP) Initial & Special Enrollment Periods (SEP) Codes
3. Medicare Supplement Basics
4. Underage Disability (DI)
5. Medicaid
6. Government Credible Health Programs
7. Helpful Phone Numbers and Resources

This guide could not possibly address all situations or questions you will encounter as you work with your Medicare clients. It is not meant to replace calling or contacting us or utilizing www.medicare.gov. Remember, please do not ever hesitate to reach out to us! We are here to assist you in every way possible.

<u>OUR OFFICE IS HERE TO ASSIST YOU AT ALL TIMES!</u>

Thank you for choosing us to meet your Senior Needs!

Shelli Young-Wiseman
Director of Senior Operations
contracting@insspecial.com

Disclaimer: The information in this document is based on our knowledge and experience. This is not intended or implied to be an official CMS or Company approved document. This is for Agent reference only

Table of Contents

SECTION 1 – 2023 MEDICARE BASIC OVERVIEW

Medicare Cost Summary

- 2023 Medicare PART A and B Premiums and PART A and B Deductibles
- 2023 Medicare Part A PREMIUM $278 or $560*
  *Amount is dependent on how long client or spouse worked and paid Medicare taxes
- 2023 Medicare Part B PREMIUM $164.90
- 2023 Medicare Part A DEDUCTIBLE $1,600.00
- 2023 Medicare Part B DEDUCTIBLE $226.00
- 2023 Medicare Supplement Plan F and G HIGH DEDUCTIBLE $2,700.00

Part A

2023 HOSPITAL – Inpatient EACH Benefit Period

- Days 1 – 60 $0
- Days 61 – 90 $400.00 per day
- Lifetime Reserve Day $800.00 per day*
  *Up to a maximum of 60 days over the client's lifetime

2023 SKILLED NURSING FACILITY– Inpatient EACH Benefit Period

- Days 1 - 20 $0
- Days 21-100 $200.00 per day

2023 Medicare Part D Coverage Gap/Donut Hole: $4,660.00 to $7,400.00

Prescription Drug (PDP) Late Enrollment Penalty

- The Late Enrollment Penalty is based upon how long client went without credible prescription drug coverage.
- Penalty is calculated by:
  - Multiplying 1% of the "National Base Beneficiary Premium" ($32.74 for 2023) times.
  - The number of FULL uncovered months* client was eligible for Medicare Part A, but did not enroll in a Medicare Prescription Drug Plan
  - This amount is then rounded to the nearest $0.10 and added to the base Prescription Drug monthly premium.

**Uncovered months = Without Credible Prescription Drug Coverage*

Medicare Options - When FIRST ELIGIBLE for Medicare

STEP 1: ENROLL - IN ORIGINAL MEDICARE

Original Medicare is a 2-part Government Provided program. Client may Enroll in Original Medicare when becoming eligible.

Part A - Covers Hospital Stays and Skilled Nursing – 80%
Part B -Covers Doctor and Outpatient Visits – 80%

STEP 2: CHOICES – "IF" CLIENT DESIRES MORE COVERAGE ***

OPTION 1:

* Keep Original Medicare and Add Medicare Supplement/Medigap coverage from Private Carriers

AND / OR ADD

* Medicare Part D plan (Prescription Drug coverage) provided by Private Companies

OPTION 2:

* Join a MEDICARE ADVANTAGE plan (Part C), provided by Private Companies. MA/MAPD plans:
    - Combines Part A and B
    - Provides Client with Additional Benefits
    - Most Plans Cover Prescription Drugs (Part D)

***NOTE: They Desire/Need more coverage, whether they know it or not!
Original Medicare does not have a "Ceiling/Cap" and does not provide Prescription Drug coverage (other than in hospital with exceptions). As you will find in the following pages, there are various ways to help cover your client's needs, from coverage to premiums. But the bottom line is, your job as an educated and caring agent is to "Cap" the unlimited ceiling of Original Medicare.

Medicare Part A and B – Basic Definitions

Medicare Part A helps cover client's Inpatient care in a HOSPITAL. Part A also includes coverage in a Critical Access hospital and Skilled Nursing Facilities (not custodial or long-term care facilities). It also covers Hospice and Home Health Care (your client must meet certain conditions to get these benefits).

Medicare Part B is the Government Insurance component of Medicare and is elective, with a monthly premium. Part B helps cover medically necessary services such as, Doctors' services, Outpatient care, Home Health care, Medical equipment, and many preventive services.

For more details and specific questions, I suggest reading and sharing with your clients:

- CMS publications "Enrolling in Medicare Part A & Part B" or "Medicare and You"
- Going to Medicare's website (www.medicare.gov)
- Call our office (800-789-0182)

Medicare Part A and B - Eligibility and Enrollment Scenarios

Client changing from the MARKETPLACE to Medicare

If client has an ACA/Marketplace plan, they MUST call the Marketplace and CANCEL their plan as of their Medicare effective date.** Client has option to keep their ACA/Marketplace plan, BUT once Medicare Part A starts, they will no longer be eligible for any premium tax credits or other cost savings they may have been receiving. They will be paying FULL premium for the Marketplace plan and can be taxed on any premium tax credit.

I suggest reading and sharing with your client CMS publication "Medicare and the Health Insurance Marketplace".

**Client must call the Marketplace and cancel their ACA/Marketplace plan. This is NOT automatically done.

Medicare and Foreign TRAVEL

Medicare usually does not cover health care while client is traveling outside the United States.* There are some exceptions, including some cases where Medicare Part B (Medical Insurance) may pay for services that a client receives on board a ship within the territorial waters adjoining the land areas of the U.S. Complete details may be found at www.Medicare.gov.

*The 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the U.S.

Note: Some Medicare Supplement insurance plans may cover clients when they travel outside the U.S. Refer to Medicare Supplement Section 3.

Medicare Part A and B Premiums 2023

Client will pay a Medicare Part B premium each month (and possible Part A premium*).

Medicare Part A Premium $0 for most people. *Premium could be up to $499 per month if neither the client nor their spouse paid Social Security taxes for at least 10 years/40 quarters.

Medicare Part B Premium $164.90 Premium may be less if enrolled in Part B before 2018 and payment deducted from Social Security. OR maybe more if client falls into high income bracket. See below:

If your yearly income in 2021 (for what you pay in 2022) was			You pay each month (in 2022)
File individual tax return	File joint tax return	File married & separate tax return	
$97,000 or less	$194,000 or less	$97,000 or less	$164.90
above $97,001 up to $123,000	above $194,001 up to $246,000	Not applicable	$230.80
above $123,001 up to $153,000	above $246,001 up to $306,000	Not applicable	$329.70
above $153,001 up to $183,000	above $306,001 up to $366,000	Not applicable	$428.60
above $183,001 and less than $500,000	above $366,001 and less than $750,000	above 97,001 and less than $403,000	$527.50
$500,001 or above	$750,001 and above	$403,000 and above	$560.50

MEDICARE ELIGIBILITY and PREMIUM CALCULATOR

Found on Medicare.gov, this is an online calculator that provides your client with an estimate of their Medicare Part B premium based on the information provided.
https://www.medicare.gov/eligibilitypremiumcalc/

APPLYING FOR MEDICARE PART A and B – EFFECTIVE DATES

EFFECTIVE DATES: ***STRONGLY suggest Client apply 3 MONTHS BEFORE TURNING 65***

Medicare Part A

Medicare Part A is an Entitlement* and goes into effect the 1st day of client's 65th birthday month.
EXCEPTION – If client's birthday is on the 1st day of the month, their coverage will start the 1st day of the PRIOR month.
*To receive "Entitlement," Social Security must reflect the client paid into Medicare and worked 40 quarters or 10 years.

For Example:

1. Client's birthday is December 15th. Medicare Part A will go into effect on December 1st.
2. Client's birthday is December 1st. Medicare Part A will go into effect November 1st.

Medicare Part B

Medicare Part B is a Voluntary Government Insurance Program. Client is responsible to pay a monthly premium for this coverage. Medicare Part B will be effective the same time as Medicare Part A unless client makes a written request to waive Part B coverage at that time. The Effective Date will always be the 1st day of the month.

When will my Medicare coverage start? NEW as of 2023

Medicare Part B coverage will begin the 1st day of the month after client signs up.

Clients should receive Medicare Part A and Part B AUTOMATICALLY if:

- Turning 65 and receiving Social Security or Railroad Retirement Board (RRB): Must meet citizenship & residency requirements (Legal residents must live in the U.S. for at least 5 years in a row, including the 5 years just before applying for Medicare).
- Under 65 and have received Disability benefits from Social Security or Railroad Retirement Board (RRB) for at least 24 months.
- Has ALS (Amyotrophic Lateral Sclerosis, a.k.a. Lou Gehrig's disease). Will start month the Social Security Disability benefits begin.
- Has End-Stage Renal Disease (ESRD) and meets certain requirements.

Medicare Part A and/or Part B Termination

Clients entitled to premium-free Medicare Part A are not permitted by law to voluntarily terminate their Part A coverage. Generally, premium-free Medicare Part A ends due to:

- Loss of entitlement to Social Security/Railroad Retirement Board benefits
- Death

Clients who pay a premium for Medicare Part A and/or Part B can be voluntarily terminated because premium payments are required. Coverage for premium paying Medicare Part A and/or Part B will end for the following reasons:

- Voluntary disenrollment request
- Failure to Pay Premiums
- Death
- For clients under age 65 (disabled or ESRD), because their Medicare Part A entitlement ends, and Part B termination follows

Client Needs to SIGN UP for Medicare Part A and/or Part B:

STRONGLY suggest Client apply 3 MONTHS BEFORE TURNING 65

- Close to 65, BUT NOT receiving Social Security or Railroad benefits. Client will need to CONTACT SOCIAL SECURITY or go to their website 3 MONTHS BEFORE TURNING 65.
  www.socialsecurity.gov/retirement
- Railroad Benefit – If a client does not sign up when they are first eligible, they may have a delay in getting Medicare coverage in the future and a possible Medicare Part B Late Enrollment Penalty.
- Have End-Stage Renal Disease (ESRD)
- Lives in Puerto Rico: Client will automatically get Medicare Part A when turning 65 OR after receiving disability benefits for 24 months. Client needs to sign up for Medicare Part B.

Note: If a client has not received notification 3 months before they should be enrolled, they need to call Social Security or Railroad Retirement Board (phone numbers listed below).

How to Sign up for Part A and Part B:

- Apply online at Social Security – www.socialsecurity.gov
- Call Social Security at 800-772-1213
- Railroad Retirement Board (RRB) at 877-772-5722

I suggest reading and sharing with your clients:

CMS publications:	"Enrolling in Medicare Part A & B"
	"Medicare & Me"
Social Security Publications:	"Retirement"
	"How Work Affects Your Benefits"
	"Retirement Information for Medicare Beneficiaries"

Applying for Medicare Part A and/or Part B AFTER INITIAL ENROLLMENT PERIOD

Typically, there are 2 options for getting Medicare Part A and/or Part B after the client's initial enrollment period fall into two categories, General or Special Enrollment.

General Enrollment Period (GEP) - NEW as of 2023

- General Enrollment Period (GEP) runs from January 1st through March 31st.
- A client may enroll during the Medicare General Enrollment period if:
  - Client does Not have Credible coverage and did not enroll in Medicare
  - Part A* and/or Part B when first eligible

    *If client is responsible for premium
- Client may sign up during the GEP from January 1st through March 31st each year
  - Coverage will begin the 1st day of the month following sign up. NEW as of 2023
    - Sign up in January - February 1st effective date
    - Sign up in February - March 1st effective date
    - Sign up in March - April 1st effective
  - The client may have to pay a HIGHER Part A and/or Part B premium due to Late Enrollment

Special Enrollment Period (SEP)

Typically, Medicare Part A and/or B, Special Enrollment scenarios revolve around a client working PAST 65 while covered under credible Group Insurance.

Following you will find:

- Potential Issue with Cobra, VA, Retiree, and Individual Health coverage enrollment
- How client may enroll when working past 65 and on Group coverage
- Possible Group Employer Claim Issue. Who Pay's 1st and Group Size

Potential Medicare Part A and/or Part B Special Enrollment Issue

COBRA, VA, RETIREE, and INDIVIDUAL Health coverage

If Client is covered under the following health plans, they DO NOT Qualify for a Medicare Part A (if responsible for premium) and/or Part B Special Enrollment Period (SEP).

- Coming off COBRA (if covered more than 8 months)
- Veteran Affairs (VA)
- Individual Health plan (Private or Marketplace)

We strongly suggest clients covered under these plans, SIGN-UP for Medicare Part A and/or Part B when initially eligible.

IF Client is covered under one of the above plans and DOES NOT sign up for Medicare Part A and/or B when first eligible, the client could have:

- Possible Medicare Part A and/or Part B Late Enrollment Penalty
- Medicare Part A ONLY and not be able to enroll into Part B until General Election Period. Client can sign up January 1st through March 31st – For February 1, March 1 or April 1st effective date

*If client is responsible for premium

FYI - This is a sad situation for these clients. We often see this affecting schoolteachers or employees that stayed on COBRA when they came off their Employer Group coverage. The only thing you can do for the client is stack ancillary plans, i.e., Cancer, Hospital Indemnity, Critical Illness, Accident, Dental, etc.

I have seen clients go back to work to have a Special Enrollment period of coming off Group coverage, but they still end up with Late Enrollment penalties.

Client IS on Credible Group Coverage and Did NOT take out Medicare PART A, and/or Part B when initially eligible:

- Client may qualify for an SEP to enroll in Medicare Part A, Part B (or both) without penalty for up to 8 months after the month client or spouse's employment or employer coverage ends, whichever comes first.
- After going on Medicare Part A and B, client may ALSO join a Medicare Advantage, a Medicare Supplement (Guarantee issue plans) or Prescription Drug plan up to 2 full months after the same event, if eligible.

FYI… Historically, clients have arranged to correlate taking out Medicare Part A and/or Part B with their Group term date. Typically, this would be 1st of the month. We are now seeing a trend where clients are coming off group plans ANY day of the month. Since Medicare Part A and B will always have a 1st of the month effective date, we suggest having client discuss options with their Group Administrator.

Client is Over 65*. Had Medicare Part B and went Back to Work. Client was then covered under Employer's Group Plan, and decided to DROP Medicare Part B. Client NOW is ready to leave Employer's Group coverage, and NEEDS to be covered under Medicare Part B again: (*Client must be OVER 65 AND on a group of 20 or more employees):

- Please call our office to discuss.

Possible Health Care Claim Issue Staying on Employer Group plan and Delaying Medicare Part B enrollment.

- "Who Pays 1st?"
  - Clients 65 and Over covered on Group of 20 or MORE Employees
    - Group pays 1st
    - Medicare pays 2nd – Typically no claim issues
  - Clients 65 and Over covered on Group with 19 or LESS Employees
    - Medicare pays 1st
    - Group pays 2nd

Potential LARGE claim issue if client stays on 19 and under group plan and DOES NOT take out Part B when initially eligible. Details and example follow:

- Example: Client is age 65 + and covered under Employer Group plan with 19 or less employees and has NO Part B coverage.
- As stated above, on Employer Groups of 19 or less – Medicare pays 1st. Thus, the client is responsible for ANY expenses incurred under Part B. Even if the client works with providers for discounts available, I have seen clients end up responsible for LARGE claim bills, especially now with so many procedures performed as Outpatient.

We recommend not staying on a group plan with 19 or less employees, unless the client is already COVERED on Part B

Clients UNDER 65 who Delayed Part "B" and covered under Employer Group - DIFFERENT RULES APPLY*

- Employers with 100 or MORE Employee's - GROUP pays 1st
- Employers with LESS than 100 Employee's - MEDICARE pays 1st

*See Under Age 65 Disability for Full Details – Section 4

MEDICARE PART A and B - LATE ENROLLMENT PENALTY

Medicare Part A Late Enrollment Penalty:

If client is NOT eligible for Premium-Free Part A* and DID NOT enroll/purchase Medicare Part A when they were first eligible (turning 65), their monthly premium may go up 10%. Client will have to pay the higher premium for twice the number of years they could have had Medicare Part A but did not sign up.

Medicare Part A Example: Client was eligible for Medicare Part A for 2 years but did not sign up. Client will have to pay 10% higher for 4 years.

*Client or spouse must have worked 40 quarters or 10 years and paid Medicare taxes through their employment

Medicare Part B Late Enrollment Penalty:

If client does not have credible coverage and DOES NOT sign up for Medicare Part B when 1st eligible OR client is on Medicare Part B, drops Part B and then goes back onto Part B, client may have to pay a late enrollment penalty for as long as they have Medicare.

Client's monthly premium for Medicare Part B may go up 10% for each full 12-month period that they could have had Medicare Part B but did not sign up.

Medicare Part B Example: Client waited 2 full years (24 months) to sign up for Part B and didn't qualify for a Special Enrollment Period, client will have to pay a 20% late enrollment penalty (10% for each FULL 12-month period that they could have signed up), PLUS the standard Part B monthly premium.

Client WILL PAY this penalty for as long as they have Medicare Part B.

Usually, a client will NOT have to pay a late enrollment penalty if they meet certain conditions that allow them to sign up for Part B during a Special Enrollment Period (SEP).

Most common Special Enrollment Period - Client Covered under Credible Employer Group / Union Health Plan.

REMINDER COBRA, VA, Retiree, and Individual Health plans are NOT considered CREDIBLE COVERAGE for Medicare Part B Enrollment

PART "C" OF MEDICARE

(Also known as Medicare Advantage)

Medicare Part C – MA /MAPD

- Medicare Advantage plans ARE NOT the SAME as Original Medicare or Medicare Supplement plans

- MA = Medicare Advantage plan

- MAPD = Medicare Advantage/Prescription Drug plan

- Medicare Advantage (HMO, PPO, PFFS, MSA and SNP) plans are offered by Medicare Approved Private Companies. Plans have a yearly limit on client's Out-of-Pocket (OOP) costs for medical services. Refer to Section 2 for plan descriptions

- Clients may Enroll in MA/MAPD Plans:
  - When first eligible for Medicare
  - During Annual Enrollment Period (AEP) (October 15th–December 7th)
  - Special Enrollment Periods (SEP)

- Anyone who is covered under Medicare Part A and eligible for Medicare Part B, may join a Medicare Advantage plan (if one is offered where the client resides).

- By law, every Medicare Advantage plan MUST cover the same benefits that are offered by Original Medicare. Clients generally receive services from a plan's set of Network providers.

HELP CLIENTS REMEMBER – They must use the ID Card sent to them from their Medicare Advantage plan to receive covered services. They need to KEEP their Medicare card in a safe place in case they need it in the future.

NOTE: While on a Medicare Advantage plan, Original Medicare will STILL cover the cost of hospice care, some new Medicare benefits, and costs for clinical research studies.

- Extra Coverages - Most Medicare Advantage plans offer some type of extra coverages. The most common are Dental, Vision, Hearing, and other Health and Wellness programs. Most include Medicare Prescription drug coverage; these are called Medicare Advantage Prescription Drug (MAPD) plans.
- Medicare pays a fixed amount for the clients covered each month to the companies offering Medicare Advantage plans. These companies must follow rules set by Medicare. However, each Medicare Advantage plan can charge different out-of-pocket costs and have different rules for how a client receives services. Carrier rules may change each year.

For Example: Does a client need a referral to see a Specialist? Do they have to go to Specific Doctors or Facilities? How much could they pay in a year?

I suggest reading and sharing with client the following CMS publications:

- "Understanding Your Medicare Advantage Plan's Provider Network"
- "Understanding Medicare Advantage Plans"

PART "D" OF MEDICARE

(Prescription Drug Coverage)

- Medicare Prescription Drug coverage helps cover the costs of Prescription Drugs. It is designed to help lower the Out-of-Pocket (OOP) costs and protect against higher costs in the future.

- Client must be entitled to Medicare Part A or enrolled under Medicare Part B to enroll in a Stand-Alone Prescription Drug plan (PDP).

- Client must have Medicare Part A and B to enroll in a Medicare Advantage Prescription Drug plan (MAPD).

- Clients may Enroll in PDP/MAPD Plans:
  - When first eligible for Medicare
  - During Annual Enrollment Period (AEP) (October 15th–December 7th)
  - Special Enrollment Periods (SEP)

- Part D is an "Optional" benefit (with a possible "Non-Optional" penalty). If a client decides to NOT join a Medicare Part D drug plan when they are first eligible, and they DO NOT get Extra Help or have Credible Prescription drug coverage, they will likely pay a late enrollment penalty. This will be added to their base Part D premium if/when they enroll in a plan later. Generally, clients will pay this penalty for as long as they have Medicare Prescription drug coverage.

- Calendar Year Deductible – resets in January. This is the amount the client must pay for their drugs before the plan begins to pay. Not all plans have a deductible. NOTE: Typically, generic drugs do not apply to deductible. Thus, if a client is taking generic drugs, they will often choose a plan with a deductible.

*Please remember to advise client…If their drugs change to a higher tier or they get sick and are prescribed one of those high dollar antibiotics (can easily start at $500 and go up) at the time, their deductible will apply first, then the client's co-pay. (This assumes the deductible was not already satisfied)

- Medicare offers drug coverage to everyone with Medicare. Medicare approved Private companies provide this coverage. Each plan can vary in cost and specific covered drugs. (Formularies)

- Formulary – Most PDP and MAPD plans have a formulary. This is a list of what drugs they will cover. Plans include both Brand-Name prescription drugs and Generic drug coverage. The formulary must include at least 2 drugs in the most prescribed categories and classes. This helps make sure clients with different medical conditions can obtain the prescription drugs they need. All Medicare drug plans generally must cover at least 2 drugs per drug category, but plans can choose which drugs covered by Part D they will offer.

- Tiers - To lower costs, many plans offering prescription drug coverage place drugs into different "tiers" on their formularies. Each plan can divide its tiers in different ways. Each tier costs a different amount. Generally, a drug in a lower tier will cost the client less than a drug in a higher tier. 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 file an exception and ask your plan for a lower copayment.

- Co-payment or Co-insurance: This is the amount client pays for covered prescriptions, after the deductible (if applicable). Client and the Drug Plan each pay their share for covered drugs. The amounts vary based on the Plan they are covered under. The amounts can Change throughout the year.

Medicare Part D Premium

- A client will pay a Medicare Part D premium for their plan each month Most clients will pay the Standard plan premium amount.
- Part "D" HIGH INCOME Premium (Often called "Part D-IRMAA")
- If a client's income is above a certain level (based on Federal Tax return filed 2 years prior), they will pay an income-related monthly adjustment amount in addition to their plan premium. Applies to Stand-Alone Part D and MAPD plans.
- Social Security will contact the client directly.
- This extra amount IS SEPARATE from their plan premium. Typically, this is taken from their Social Security check. (Exception – it could be billed from Medicare or the Railroad Board.)
- A client is required to pay the Part D-IRMAA, even if their Employer or 3rd Party (like a Teacher's Union or a Retirement system) pays for their Part D plan premium. If premium is not paid, client is disenrolled AND they could also LOSE their RETIREMENT coverage and not be able to get it back.

Note: This is SEPARATE from a Part D late penalty, which is added to client's plan premium and billed from the plan carrier.

If your yearly income in 2021 (for what you pay in 2022) was			You pay each month (in 2022)
File individual tax return	File joint tax return	File married & separate tax return	
$97,000 or less	$194,000 or less	$97,000 or less	Your Premium
above $97,001 up to $123,000	above $194,001 up to $246,000	Not applicable	$12.20
above $123,001 up to $153,000	above $246,001 up to $306,000	Not applicable	$31.50
above $153,001 up to $183,000	above $306,001 up to $366,000	Not applicable	$50.70
above $183,001 and less than $500,000	above $366,001 and less than $750,000	above 97,001 and less than $403,000	$70.00
$500,001 or above	$750,001 and above	$403,000 and above	$76.40

Medicare Part D – Late Enrollment Penalty

The Medicare Part D Late Enrollment Penalty is an amount that is added to a client's Part D premium. The client may owe a late enrollment penalty, IF at any time AFTER their Initial Enrollment Period is over, there is a period of 63 or more days in a row when client did NOT have Medicare Part D or other Credible Prescription Drug coverage.

- Generally, client will pay penalty for as long as they have Medicare Part D coverage
- The National Base Beneficiary Premium may change each year; thus, client's penalty could be different from year to year.
- Penalty calculations will come direct from CMS via Company billing
- If client receives Extra Help, they do not pay a late enrollment penalty.

NOTE: If client is on Medicare Disability and has incurred a Late Enrollment penalty, when the client turns 65 it will go away. (Refer to Section 4)

June 1, 2006: Medicare Prescription Drug (Rx) Late Enrollment Penalty was implemented. Occasionally, you may come across a client who has no creditable coverage and has never had a PDP plan. This date gives you a starting point.

How to calculate Medicare Part D Late Enrollment Penalty:

The late enrollment period is calculated by multiplying 1% of the "National Base Beneficiary Premium" ($32.74 in 2023) times the number of full uncovered months the client was eligible but did NOT join a Stand Alone or Medicare Advantage Prescription Drug plan and went without other Credible prescription drug coverage. The final amount is rounded to the nearest $0.10 and added to the client's monthly premium.

Example: Mrs. Goodrich has Medicare, and her first chance to get Medicare drug coverage (during her Initial Enrollment Period) ended on July 31, 2020. She doesn't have prescription drug coverage from any other source. She didn't join a Medicare drug plan by July 31, 2020, and instead joined during the Annual Enrollment Period (AEP) that ended December 7, 2022. Her Medicare drug coverage started January 1, 2023.

Since Mrs. Goodrich was without creditable prescription drug coverage from August 2020 through December 2022, her penalty in 2023 is 29% (1% for each of the 19 months) of $32.74 or $9.49 each month. Since the monthly penalty is always rounded to the nearest $0.10, she will pay $9.50 each month in ADDITION to her plan's monthly premium.

$32.74 (2023 National Base Beneficiary Premium) x 0.29 (29% penalty)
$ 9.49 (rounded to the nearest $0.10 = $9.50) will be Mrs. Goodrich's monthly late penalty for 2023

NOTE: The National Base Beneficiary Premium changes each year, so her penalty may also change each year. This monthly penalty is added for as long as she has Medicare Drug Coverage, even if she switches plans.

Credible Prescription Drug Coverage for Medicare Part D Rx

(Differs from Health side)

Most common examples of Credible Drug Coverage:

- Creditable Employer Group or Union Coverage
- Indian Health Services (IHC)
- TRICARE
- Veteran Affairs (VA)

Most Medicare Prescription Drug plans have a coverage gap (also called the "Donut Hole"). The coverage gap begins after the client and their drug plan TOGETHER, have spent a certain amount for covered drugs.

In 2023, once client enters the Coverage Gap / Donut Hole ($4,660.00 to $7,400.00), they will pay 25% of the plan's cost for covered Brand-Name drugs and 25% of the plan's cost for covered Generic drugs until the client reaches the end of the coverage gap.

Note: NOT EVERYONE will enter the coverage gap because they have low or no drug costs.

2 Examples:

BRAND NAME Drugs: Mrs. Hoyer reaches the coverage gap in her Medicare drug plan. She goes to her pharmacy to fill a prescription for a covered brand-name drug. The price for the drug is $60, and there's a $2 dispensing fee that gets added to the cost, making the total price $62. Mrs. Fox pays 25% of the total cost ($62 x .25 = $15.50).

GENERIC Drugs: Mr. Big reaches the coverage gap in his Medicare drug plan. He goes to his pharmacy to fill a prescription for a covered generic drug. The price for the drug is $20, and there's a $2 dispensing fee that gets added to the cost. Mr. Evans will pay 25% of the plan's cost for the drug and dispensing fee ($22 x .25 = $5.50). The $5.50 he pays will be counted as out-of-pocket spending to help him get out of the coverage gap.

2023 Medicare Part D Drug Coverage Gap (Doughnut Hole) is $4,660.00 to $7,400.00

The coverage gap begins when the cost of client's drugs reaches $4,660.00 for 2023. (Remember… this is a combination of the client and the drug plan's costs).

The costs (Sometime called True Out-of-Pocket, or "TrOOP" costs) ALL COUNT towards client getting out of the Coverage Gap and include:

- Yearly Deductible, Co-Insurance and Co-Payments
- The discount the client gets on covered Brand-Name drugs in the Coverage Gap PLUS the amount the Company pays
- Amount client pays in the Coverage Gap

NOTE:

- The Drug Plan Premium and what the client pays for drugs that ARE NOT covered by the Drug Plan DO NOT count towards getting out of the Coverage Gap.
- Some plans offer additional Cost Sharing reductions in the coverage gap, beyond the standard benefits, and discounts on Brand-Name and Generic drugs.

CATASTROPHIC COVERAGE

Once the cost of the drugs has reached $7,400.00 for 2023, client is out of the Coverage Gap / Donut Hole and AUTOMATICALLY will go onto “Catastrophic Coverage”

When in Catastrophic Coverage, client pays Reduced Co-pays for covered drugs the rest of the year.

NOTE: If client receives Extra Help, they will not have some of these costs.

FYI - When you are quoting client on Medicare.gov, your printout will break the sections out.

Suggested PDP reading for you and your clients from CMS Publications:

- “Things to think about when you compare Medicare Drug Coverage”
- “Your Guide to Medicare Prescription Drug Coverage”
- “4 Ways to Lower Your Medicare Prescription Drug Costs”
- “How Income affects your Medicare Prescription Drug Coverage”

SECTION 2 – MEDICARE PART C and D

Part C and D: Highlights, Plan Basics, and Agent Tips

- **2003:** The ***Medicare Prescription Drug Improvement Modernization Act of 2003*** brought forth Prescription Drug and Medicare Advantage Plans for the future.
- **2005:** Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD) and Prescription Drug (PDP) plans were introduced and sold for 2006 effective dates
- **July 1, 2006:** Prescription Drug (Rx) Late Enrollment Penalty was implemented. Occasionally, you may come across a client who has no creditable coverage and has never had a PDP plan. This date gives you a starting point.
- **MA Only PFFS (Private Fee for Service):** This is the **ONLY plan** you may write WITH a **Stand-Alone PDP**.
- **Medicare** eligible **Dual beneficiaries** or **"Duals":** Individuals who qualify for both Medicare **AND** Medicaid.
- ****5-Star Rating:** Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. Rating can be between 1 and 5 stars. A **5-Star rating is considered excellent**. The ratings help you compare plans based on quality and performance. Medicare updates these ratings each fall for the following year.
- Client **MUST reside** in the plan's Service Area.

Note: In the fall, when you receive your initial supplies from the carriers, they often do not include the Star Ratings. Upon receipt from the carriers, you MUST add to your applications the Outline of Coverages to give to your client. Client MUST receive a copy.

Annual Election/Enrollment Period (AEP) runs October 15th through December 7th

- **All applications** submitted during **Annual Enrollment with AEP Election Period Code applied**, will be effective **January 1st** of the following year.
- During this time frame, a Medicare eligible person may **Enroll** in a plan, **Change** a plan, or **Remain** on the plan they currently have (assuming plan is still available).

- **The Annual Enrollment (AEP) time frame DOES NOT apply to Medicare Supplements**. ***But…it is a perfect time to review*** when you are helping a client with their PDP drug plan.

- **We strongly suggest** reviewing a client's MA/MAPD/PDP plan annually in the fall, due to possible provider network and/or formulary drug changes.

Each year, we see issues when the client indicates they decline to meet or review because they are "satisfied or happy" with their plan (that is the Goal!). But, unfortunately after January 1st, we often hear back from the same "happy" client who decided not to review and did not read their ANOC/EOC packet (see below) to see what changes applied to them. Most common ***"unhappiness"*** occurs from client discovering:

- Their Doctor or Provider is **NO longer in their network OR**
- They just left the Pharmacy and either their **co-payment is higher** than it was in December, or their Drug is not covered under the carriers Formulary.

- **Call us.** We are here to help you with this process. We can provide you with ideas and sample letters you can send to your clients on or after October 1st.

Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) Letters:

If your client has a MA/MAPD/PDP plan, their insurance carrier must have information to them by September 30th. Letters include any changes effective January 1st.

- ***Evidence of Coverage (EOC):*** Provides client specific details about their current plan coverages.
- ***Annual Notice of Change (ANOC):*** Advises client on Annual changes. It will highlight a side-by-side view of each item for the current year and what it will be the next year if the client remains on the plan.

Quoting MA/MAPD/PDP plans www.medicare.gov:

Call our office and we can discuss options and walk you through the quoting site together.

Client fails to pay premium on their MA/MAPD/PDP plan:

The company **MUST** notify the enrollee in writing and provide the enrollee with a Grace Period of **NOT LESS** than 2 months.

NOTE: **Exceptions** apply for Dual Eligible and Part D Low Income Subsidy (LIS) clients. Medicare may extend the grace period for "Good Cause" and reinstate their enrollment within 90 days. Client must pay all premium due.

Cancellation of MA/MAPD/PDP plan due to Death:

Policy will cancel automatically once Social Security is notified.

Plan EFFECTIVE dates will ALWAYS be the 1st of the month

- **Effective Date Rule and Possible ISSUE:**

Based on eligibility, Medicare always Assigns the **FIRST Available Effective date possible.**

- **Possible ISSUE**:
  - If client is first eligible for Medicare but wishes to **not have a policy effective until later** (still in Enrollment time frame), you must **NOT** write/submit the application until the month **BEFORE** the desired effective date. If you submit the application before that, the client will **automatically** be given the next eligible effective date, **EVEN** if a future date is requested on the application.

Example:

In July, you met a new client, Mrs. Mosby. She is eligible for Medicare Part A and Part B effective August 1st. Mrs. Mosby decides she wants a Medicare Supplement policy and a Stand-Alone Prescription Drug plan (PDP). But **she does not want the PDP coverage to begin until the end of her eligibility timeframe**. In this scenario, she would need an effective date of December 1st (month of and 3 months after). You will need to meet with Mrs. Mosby again in **November to write and submit the application for December 1st effective date**.

- **No Money** is to be submitted with a MA/MAPD/PDP application

- **Most common Premium Payment Options**

- Automatic Deduction from Social Security or Railroad Retirement benefit check
- Automatic Bank Withdrawal from Checking or Savings Account
- Coupon Book

Applications

- Typically, applications **need to be submitted to the Carrier OR our office** within **24** hours of the **date the AGENT signs the application**. Applications **MUST** be submitted direct to the carrier OR to our office**. For details refer to our *Everyday Operations Guide document.***

- **The DATE AGENT SIGNS APP STARTS THE TIMER!!**

- **Multiple applications during Annual Enrollment (AEP)**: You may write Multiple PDP/MAPD applications on a client during this season. **Last application in COUNTS.**

- **To Write** MA/MAPD/PDP **New Business** and **Keep Renewal** business/commissions on the books, **each year** an Agent **MUST:**
  - Take and pass **AHIP** certification (America's Health and Insurance Plans)
  - Be **COMPANY Appointed AND CERTIFIED** with **ALL plans and carriers** they are going to represent *****
  - **Agent must** be **RTS** (**Ready to Sell**)
  - **Specific Details are found in our *Everyday Operations Guide* document**

Note: If you have **business on the books and decide to no longer sell New Business,** you **STILL HAVE TO CERTIFY to keep renewal business on the books.**

Agent of Record (AOR) changes:

- Typically, Agent of Record changes are NOT allowed. You cannot write an application for a client with the same plan they currently are covered on. It will be DENIED.

MARKETING and COMMUNICATION:

- **Agents may begin marketing Annual Enrollment (AEP) Plans** to potential clients on **OCTOBER 1st of each year**.
- **LETTERS/POSTCARDS - Annual AEP Client Letters/Postcards MUST NOT be POSTMARKED before OCTOBER 1st.**
- **E-MAILS - If sending out E-mail, there MUST be an OPT-OUT option included.**

NOTE*:** If you are "Advertising or Helping" anyone with a MA/MAPD/PDP plan and you **HAVE NOT** taken **AHIP** and/or **CERTIFIED WITH THE CARRIER** you are discussing, you are going **AGAINST CMS RULES!!** If caught, you are looking at major penalties and a possible **LOSS** of your Insurance license! ***We can help – just call!

Health Maintenance Organization (HMO): In HMO Plans, a client generally must get their care and services from providers in the plan's network, except:

- Emergency care
- Out-of-area urgent care
- Out-of-area dialysis

- **Typically, a client will:**

- **Choose a Primary Care Doctor:** *Note:* If their doctor or other health care provider leaves the plan, they will be notified and can choose another Doctor in the plan.
- **Obtain a Referral to see a Specialist:** Certain services, for example, yearly screen mammograms, do not require a referral.
- **Pay full cost if they go Outside of the Health Care plan's Network.**

➢ **To obtain Prescription Drug coverage**, a client must join an HMO Plan that offers prescription drug coverage. If client joins a HMO Plan that does not offer prescription drug coverage, they cannot join a Stand-Alone Prescription Drug plan (PDP)

Preferred Provider Organization (PPO):

➢ PPO Plans have network doctors, other health care providers, and hospitals. A client pays less if they use doctors, hospitals, and other health care providers that belong to the plan's network. They pay more if they use doctors, hospitals, and providers outside of the network.
- Client **does not** need to choose a Primary Care Doctor
- **In most cases, a client does not** have to get a referral to see a specialist.
- **To obtain Prescription Drug coverage**, a client must join a PPO Plan that offers prescription drug coverage. If client joins a PPO Plan that does not offer prescription drug coverage, they cannot join a Stand-Alone Prescription Drug plan (PDP)

Private Fee-for-Service (PFFS):

➢ PFFS plans determine how much it will pay doctors, other health care providers, and hospitals, and how much a client must pay when they receive care.
- Client can go to **any** Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat them. **Not all providers will.**
- Client **does not** need to choose a Primary Care Doctor
- Client **does not** have to get a referral to see a specialist
- Some PFFS Plans contract with **a network of providers** who agree to always treat the client even if they have never seen them before.
- Out-of-network doctors, hospitals, and other providers **may decide NOT to treat a client even if they have seen them before.**
- **For each service they receive,** make sure their doctors, hospitals, and other providers agree to treat them under the plan, and accept the plan's payment terms.
- In an emergency, doctors, hospitals, and other providers must treat clients.
- Client needs to show their plan membership ID card each time they visit a health care provider. **Their provider can choose at every visit whether to accept** their plan's terms and conditions of payment.
- Client **only needs to pay the co-payment or co-insurance** amount allowed by the plan for the type(s) of service they receive at the time of visit.

➢ **Prescription drugs may be covered in PFFS Plans. If their PFFS Plan does not offer drug coverage, client may join a Medicare Prescription Drug Plan (Part D). A PFFS plan is the only plan that allows for a Stand-Alone Part D to also be written.**

Medicare Medical Savings Account (MSA):

➢ MSA plans are like Health Savings Account Plans available outside of Medicare. A client can choose their health care services and providers.

➢ Medicare MSA plans **cover** the **Medicare services that all Medicare Advantage Plans must cover**. In addition, some Medicare MSA plans may cover extra benefits for an extra cost, like:
- Dental

- Vision
- Long-term care not covered by Medicare

- Medicare MSA Plans **DO NOT cover Medicare Part D Prescription Drugs.** If a client joins a Medicare MSA Plan and needs drug coverage, they will need to join a Stand-Alone Prescription Drug plan.

There are 2 Parts to a MSA plan:

Medicare MSA Plans combine a high-deductible insurance plan with a medical savings account that a client can use to pay for health care costs.

1. **High-deductible health plan:** The first part is a special type of high-deductible Medicare Advantage Plan. The plan will only begin to cover clients costs once a client meets a high yearly deductible, which varies by plan.
2. **Medical Savings Account (MSA):** The second part is a special type of savings account. The Medicare MSA Plan deposits money into the client's account. They can use money from this savings account to pay health care costs before they meet their deductible.

Steps for a client to use a Medicare MSA Plan

Choose and join a high-deductible Medicare MSA Plan.

1. Set up an MSA with a bank the plan selects.
2. Medicare gives the plan an amount of money each year for their health care.
3. The plan deposits some money into their account.
4. Client can use the money in the account to pay health care costs, including health care costs that are not covered by Medicare. When account money is used for Medicare-covered Part A and Part B services, it counts towards their plan's deductible .
5. If they use all the money in their account and have additional health care costs, they will have to pay for their Medicare-covered services out-of-pocket until they reach their plan's deductible.
6. During the time client is paying out-of-pocket for services before the deductible is met, doctors and other providers cannot charge them more than the Medicare-approved amount.
7. After the client reaches their deductible, their plan will cover their Medicare-covered services. They should read information from the plan for details about out-of-pocket costs .
8. Money left in account at the end of the year stays in the account and may be used for health care costs in future years.
9. If a client does use funds from their account, they must include IRS form #8853 when they file taxes.

Special Needs Plans (SNP):

Medicare SNP plans limit membership to people with specific diseases or characteristics. Medicare SNP's tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve. The **plans offer benefits in addition** to those covered under Original Medicare such as routine dental, vision, hearing, transportation, and routine podiatry services. ******Clients who qualify for these plans have additional enrollment options***

- **All SNPs must provide Medicare prescription drug coverage.**
- A plan must limit membership to these groups: **1)** people who live in certain institutions (like a nursing home) or who require nursing care at home, or **2)** people who are eligible for both Medicare and Medicaid, or **3)** people who have specific chronic or disabling conditions (for example, diabetes, chronic heart failure and many more). Plans may further limit membership.

- Note: **Chronic conditions differ per carrier, county, and state**. You must refer to a specific carrier and their plan offerings.
- Plans should coordinate the services and providers needed to help clients stay healthy and follow doctor's or other health care provider's orders.
- If client has Medicare and Medicaid, plan should make sure that all of the plan doctors or other health care providers they use accept Medicaid.
- If a client lives in a Nursing Home (Nursing Home = Institution per Medicare), they should make sure the plan providers serve people where client live.

Covered under Employer Group and Medicare Advantage Prescription Drug (MAPD) plan at the Same Time:

- If a client is considering **having coverage under a MAPD plan AND Employer Group Coverage,** it is strongly suggested the client **talk** to their Employer, Union or other Benefit Administrator about their coverage rules.
- In some cases, if a client would take out a Medicare Advantage plan **in ADDITION** to their Group coverage, their Employer/Union group may cancel their coverage. AND **not allow** client to rejoin the Group.

Covered Under Medicare Advantage (MA/MAPD) and Medicare Supplement plan at the Same Time:

- **Client is currently covered under a MAPD plan**:
  - It is **ILLEGAL** for anyone to sell a Medicare Supplement policy to a client UNLESS they are switching to Original Medicare and taking out a Stand-Alone PDP plan.

- **Client is currently covered under a Medicare Supplement plan:**
  - While covered under a Medicare Supplement plan, clients join a MAPD plan while continuing to pay premiums and **not canceling** their Medicare Supplement plan. This is ***NOT recommended***! The MAPD plan pays the client's approved claims, thus the Medicare Supplement plan will pay **NO claims** because the client **IS NO LONGER** on Original Medicare. If you run into this situation, please call our office and we can strategize.

Dual Enrollment Period:

INITIAL Enrollment *vs* ANNUAL Enrollment

During Annual Enrollment Period (AEP), clients have an **Initial** Enrollment Period **(Turning 65 AND getting Medicare Part A and B**) available to them with a **January 1st** effective date.

*We Suggest **ALWAYS using the Initial Election Code.***

This would allow the client the back-up options of going to Original Medicare within the first 12 months of taking out a MA/MAPD plan (and then take a Medicare Supplement and PDP plan)

If the AEP code is used, **the client will not have this option**.

- The Election Code for going back to Original Medicare reads: ***"I enrolled in an MA/MAPD plan upon turning 65 and going onto Medicare Part A and B, and I want to leave that plan and go back to Original Medicare".*** **Code: SEP65**

Benefit Coordination and Recovery Center

- Occasionally, the client will discover that **Medicare's system does not reflect the current Carrier/Product for which they are enrolled.**

Example:

- **Medicare Supplement replacement:** Carrier A is replaced with Carrier B, but Medicare still reflects Carrier A.

OR

- **Client comes off Employer Group plan**, takes out other coverage and Medicare still reflects the Group coverage.

We typically become aware of this when:

- Client's Medicare Supplement claims are **denied due to no coverage with the carrier**

OR

- Client presents a pharmacy with their new PDP/MAPD ID card and the pharmacy indicates **client is still covered under their group plan.**

If this occurs, client needs to reach out to the ***Benefits Coordination and Recovery Center***. This is a 3rd party organization that helps Medicare know what carrier is primary on each beneficiary and helps to fix Medicare's system to correctly reflect client's coverage.

Phone number: **855-798-2627. They will ask the client to supply details about their previous and current coverage, including dates of coverage.**

Suggested reading for you and your clients from CMS Publications:

- ***"Coordination of Benefits: Getting Started"***
- ***"Understanding Medicare Part C & D Enrollment Periods"***
- ***"Medicare and You"***

ENROLLMENT PERIODS FOR MEDICARE PART C and D

IEP (Initial Enrollment Period):

- **MAPD - Client is New to Medicare** (i.e., within IEP period), enrolled in both Medicare Part A and Part B, and plans to enroll in Medicare Advantage plan **WITH Rx** coverage (MAPD plan).
- **Client has:**
  - 3 months to enroll **before** eligible Effective date
  - Month **"of"** the Effective date
  - 3 Months **After** the Effective date

OR

- **PDP - Client is New to Medicare** (i.e., within IEP period), enrolled in Medicare Part A and/or Part B, and plans to enroll in Prescription Drug coverage (PDP plan).
- **Client has:**
  - 3 months to enroll **before** eligible Effective date
  - Month **"of"** the Effective date
  - 3 Months **After** the Effective date
  - **ONLY** one Election Period

ICEP (Initial Coverage Enrollment Period):

- **Client is New to Medicare** (i.e., within IEP period), enrolled in both Medicare Part A and Part B, and plans to enroll in Medicare Advantage plan **WITHOUT Rx** coverage (MA plan).
- **Client has**:
  - 3 months to enroll **before** eligible Effective date
  - Month **"of"** the Effective date
  - 3 Months **After** the Effective date

  OR
- **Client's IEP period expired. They delayed Part B enrollment, and** plan to enroll in Medicare Advantage plan **WITH or WITHOUT Rx** coverage (MA or MAPD) in the **3 months before Part B effective date.**
- **Client ONLY has:**
  - 3 months to enroll **before** eligible Effective date
  - **ONLY** one Election Period

IEP2 (Initial Enrollment Period 2):

- **Client had Medicare previously but has recently turned 65**
- For **MAPD/PDP** plans (**NOT** for MA plans)
- **Client has:**
  - 3 months to enroll **before** eligible Effective date
  - Month **"of"** the Effective date
  - 3 Months **After** the Effective date
  - **ONLY** one Election Period

AEP (Annual Enrollment Period):

- For **MA/MAPD/PDP** plans
- Enrollment period is **October 15th through December 7th**
- All policies written with AEP code are effective January 1st
- During AEP, the **last** application submitted to the carrier is what is I**ssued**

MA OEP (Medicare Advantage Open Enrollment Period):

- Enrollment Period runs **January 1st – March 31st.**

Important - Agents are NOT ALLOWED to Market this enrollment period.

- **Client is enrolled in an MA/MAPD/SNP plan as of January 1st and wants to change to a different MA/MAPD/SNP plan**.
- **Effective dates available**:
  - **Enroll in January = February 1st effective date**
  - **Enroll in February = March 1st effective date**
  - **Enroll in March = April 1st effective date**

- **During the MA Open Enrollment Period, current MA/MAPD/SNP:**
  - **Enrollees MAY:**
    - **Change** to a different MA/MAPD/SNP plan **OR**
    - **Disenroll** from their MA/MAPD/SNP plan (Returning to Original Medicare) and take out Stand-Alone Part D

- **Enrollees MAY NOT:**
  - Client **MAY NOT** switch to another Stand-Alone PDP plan
  - Client may only change plans **ONCE** during the MA OEP time period
  - The Open Enrollment Period **does NOT provide enrollment rights** to a client who is not enrolled in a MA or MAPD plan

SEP (Special Enrollment Period):

- **For MA/MAPD/PDP plans**
  - Client may enroll or make changes to their Medicare Advantage, Medicare Advantage Prescription Drug or Prescription Drug plans when certain events happen in their life (for example: Residence change or Loss of other coverage).
  - These changes are called **Special Enrollment Periods** and are in addition to the regular enrollment periods that occur each year. Starting on Page 59, you will find details on the most Common SEP timelines, codes, and enrollment scenarios.

For more comprehensive details showing when changes may be made and the type of changes allowed, please *refer to the attached **ELECTION PERIOD BOOKLET** in our resource section.*

OEPI (Open Enrollment Period for Institutionalized Individuals)

Nursing Home and Specific Care Facilities:

- Client Moves into, Resides in, or Moves out of a **Skilled Nursing Facility** (SNF), **Nursing Facility** (NF), **Intermediate Care Facility for the mentally disabled, Psychiatric Hospital**, **Rehabilitation Hospital, Long-Term Care** (LTC) **Hospital**, or **Swing Bed Hospital** (with expected stay of at least 90 days)
- **CONTINUOUS** Elections allowed
- For **MA and MAPD** plans the **Election Period is Institutionalized** and **Election Code is OEPI.**
- For **PDP** plans the **Election Period is also Institutionalized**, **BUT** the Election Code is an **SEP.**
- **Client may enroll the 1st day** of the month following receipt of the election for:
- **Going INTO** facility
- **Residing IN** the facility
- **Being DISCHARGED** from the facility

NON -RENEWING Medicare Advantage Plan (MA/MAPD)

- Plan will no longer be Offered in client's area.
- **Enrollment runs - December 8th through the last day of February**

- **MA/MAPD/PDP** - This is a Special Enrollment Period (SEP). I am bringing this to your attention **because** this SEP has its **Own Time Period.**
  - Carriers should notify clients covered under ***"Non-Renewing"*** **MA/MAPD/ PDP plans** by September 30th. These letters are called ***ANOC*** letters (Annual Notice of Coverage Change) and will indicate their plan will not be offered as of January 1st of the following year.
  - Client has from **December 8th through the last day of February of the following year** to enroll in another MA/MAPD/PDP plan. (This is in **ADDITION to the AEP** time period of October 15th through December 7th).
  - Enrollments made **October 15th - December 31st will be effective January 1st**
  - Enrollments made in **January will be effective February 1st**
  - Enrollments made in **February will be effective March 1st**
  - **MA/MAPD/PDP: SEP code: Termination/ Non-Renewal**

- ****Medicare Supplement:**
  - Client has the option of moving to a Guarantee Issue Medicare Supplement plan with effective date options of January 1st through March 1st. Plans listed below.
  - You would also want to write **Stand Alone PDP Plan** on client.

*****Note:*** As indicated, client has option to take **Medicare Supplement** plan for **any available effective date** between January 1st and March 1st. Prescription Drug Plans (PDP) **ALWAYS** have **1st of the month effective dates**. Please keep this in mind as you are helping your client.

- **Guarantee Issue Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

Suggestion: **Many times, agents will wait and schedule client appointments until after December 7th when Annual Enrollment Period (AEP) is over. You will still have time to meet the client's needs with a January 1st effective date.**

Note: **If you do write between October 15 and December 7th, you must use AEP enrollment code, NOT SEP code.**

COMMON MA/MAPD and PDP ENROLLMENT SCENARIOS

Time Periods, Election Codes and Medicare Supplement Cross Over Information

- **Client Newly Eligible for Medicare - Getting Part A and B for the 1st time:**
  This is an **Initial Enrollment Period** for client:

- **As of Medicare Part A and B effective date, Client may:**
  - **Take out MA only plan**
    - Election Period: Newly Eligible Election Period Code: **ICEP**
    - (3 months before – Month Of – 3 months after)
  - **Take out MAPD plan**
    - Election Period: Newly Eligible Election Period Code: **IEP**
    - (3 months before – Month Of – 3 months after)
  - **Take out Stand-Alone PDP** plan
    - Election Period: Newly Eligible Election Period Code: **IEP**
    - (3 months before – Month Of – 3 months after)
  - **Take out a Medicare Supplement** plan
    - 6 months Before and After effective date
    - Medicare Supplement Plans available:
      Eligible for Part A **On/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**

- **Turning 65 – Already on Medicare Part A and B:**
  Client was eligible for Medicare previously but has recently turned 65. "Aging In"

  This is a **NEW Initial Enrollment Period** for the client:
- **Client may:**
  - **Take out MAPD plan**
    - **Election Period:** Age-In (Eligible Prior to Age 65) Election Period Code: **IEP2**
    - **Enrollment:** Client has 3 months before – Month Of – 3 months after the **1st day of their 65th birthday month**
    - **Effective Date may not be before the 1st day of 65th birthday month**
  - **Take out Stand-Alone PDP** plan **
    - Election Period: Age-In (Eligible Prior to Age 65) Election Period Code: **IEP2**
    - **Enrollment:** Client has 3 months before – Month Of – 3 months after the **1st day of their 65th birthday month**
    - **Effective Date may not be before the 1st day of 65th birthday month**

    ***** NOTE: If client has accrued a PDP Late Enrollment penalty, the slate is now wiped clean!***
  - **Take out Medicare Supplement plan**
    - 6 months Before and After **1st day of their 65th Birthday month.** Would also want to write a Stand-Alone PDP plan
    - Medicare Supplement Plans available:
      Eligible for Part A **On/or After** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
      Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**

- **Client took out a MA/MAPD plan *(using IEP code)* when Turning 65 AND enrolling in Medicare Part A and B for the 1st time.**
  - ***NOW…*the client wants to DIS-ENROLL back to Original Medicare and take out a Medicare Supplement and Stand-Alone PDP plan:**
  - At the age of 65 and enrolling in Medicare Part A and B, client took out a MA/MAPD plan. Client **MAY** decide to not stay with the MA/MAPD plan and **Dis-enroll** within the 1st year (12 months). Client would then be on Original Medicare and **has the option** to take out a Medicare Supplement and/or a Stand-Alone PDP plan.

Note:
- **Does NOT apply to UNDER 65 age Disability clients**
- **ONLY applies** to a client who enrolled in MA/MAPD plan when turning 65 **AND ALSO** getting Medicare Part A and B for the first time

To Accomplish this:
- **Medicare Supplement:** Client may enroll in any available Medicare Supplement plan within the 12-month time period.
  - **Eligible plans to enroll in:**
    Plans A, B, D, G, HDG, K, L, M, N

- **Stand-Alone PDP**: Client also needs to take out PDP plan with in the 12-month time period.
  - Election Period: First Time MA Member (Age-In)
  - Election Period Code: **SEP 65**

- **Client was covered under a Medicare Supplement plan. Client then decided to enroll in a MA/MAPD plan for 1st time.**
  - ***NOW…*** **Client wishes to Dis-enroll and go Back to their Medicare Supplement plan within 12 Months:**
  - When client drops their Medicare Supplement plan to enroll in a MA/MAPD plan, this is called a **1st Year "Trial Period"**. During this time, the client may go back to Original Medicare and return to the **SAME Medicare Supplement plan and Carrier** they were previously on. Client will also need to enroll in Stand Alone PDP plan. **To accomplish this:**

- **Medicare Supplement:** Client **HAS TO** go back to the **SAME Med Supp Carrier**** and **Plan** they were on before they enrolled in MA/MAPD plan for the 1st time.
  - Medicare Supplement **premiums** must have been **PAID CURRENT.** No gap in coverage going from Medicare Supplement to MA/MAPD plan.
  - 12-month clock starts on MA/MAPD effective date.
  - The Medicare Supplement carrier will want **PROOF** of the MA/MAPD policy termination before re-issuing the prior Medicare Supplement policy. This will be the "official" termination letter client will receive from MA/MAPD carrier and MUST state a **SPECIFIC** termination date. **

- **Stand Alone PDP**: When written, will cancel the MA/MAPD policy.
  - Election Period: Consumers in an MAPD who drop Medicare Supplement and are in Trial period.
  - Election Period Code: **SEP-Indiv drop Medigap-Trial Period**

**Medicare Advantage TRIAL PERIOD

- If a client has utilized the Medicare Advantage Trial Period (on a Med Supp, then takes out an MA plan for the 1st time and decides they do not want to stay with the plan, they **have the right to go back to the same Plan and Carrier they were on before, guarantee issue within 12 months.**

- **POSSIBLE ISSUE** - IF the Medicare Supplement carrier is no longer available, they have the right to go to another carrier guarantee issue. **BUT… they must follow the NEW January 2020 Guarantee Issue Plan Rules.**

For EXAMPLE: Client went onto Medicare in 2018 and took out a Medicare Supplement Plan G. Client decided to try a Medicare Advantage plan and has now decided they want to go back to their Medicare Supplement Plan G.

- If their Medicare Supplement carrier is still available – no problem.
- If their Medicare Supplement carrier is **not still available**, (example, Transamerica) this client would **not have the option to go back to a "G"** plan guarantee issue, since eligible for Medicare prior to 1-1-2020 and the Guarantee Issue plans before 1-1-2020 are A, B, C, F, K or L.
- This client would need to take out a plan A, B, C, F, K, or L to be guarantee issue.
- Of course, they always have the option to go through underwriting to get a different plan. (AARP is best route if medical issues)

Working past 65 Client and Coming Off Employer or Union Qualified Group Plan, ALREADY "Enrolled" in Medicare Part A and B***:

- **MA/MAPD/PDP** **Time Frame, Effective Date and Enrollment Code:*****
- **Time Frame**:
  - **Begins** month group allows for disenrollment **OR** date COBRA ends.
  - **Ends 2** months after group coverage ends
  - **Effective Date:**
  - Can choose an effective date up to 3 months in advance after receipt of election **but not** earlier than the first of the month following the month in which the request is made.
  - **Election Period:** Loss of Employer Group Coverage (Group Retiree, COBRA, and Commercial Coverage)
  - **Election Period Code: SEP – Loss of EGHP Coverage / LEC**

- **Medicare Supplement:** Client also has the option to take out a Medicare Supplement plan within **63 days.** Must be a Guarantee Issue plan.
- **Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- Client will need to provide proof of group coverage termination. This includes:
  - ✓ Group carrier name
  - ✓ Policy number
  - ✓ Client and/or Spouse's name
  - ✓ Policy Effective date
  - ✓ SPECIFIC Termination date. * See CCC information below
- ****Certificates of Credible Coverage (ccc)*** usually have all the information that is needed but are not provided to client until 30 days AFTER the group termination. ***Thus, if client will work with their HR department, the carrier will typically accept a Signed letter on Group letterhead, indicating the above needed information.***

****We suggest (if any way possible) to place the client coming off Employer Group who already has Medicare Part A and B on a Medicare Supplement plan. This would be the ONLY WAY a client would have the option for a "Trial Period" under a MAPD plan.***

Working past 65 and Coming off Employer or Union Qualified Group Plan. Has Medicare Part A – "DELAYED" enrolling in Medicare Part B**:

Historically, a client would apply for Medicare Part B, correlating the Group termination date with the Medicare Part B effective date (1st of the month). **Today, we are seeing clients coming off group plans ANY day of the month. Since Medicare Part B will always have 1st of month effective date, we suggest having client discuss this with their Group Administrator.**

- **MA/MAPD/PDP Time Frame, Effective Date and Enrollment Code***:**
- **Time Frame**:
  - **Begins** month group allows for disenrollment **OR** date COBRA ends.
  - **Ends 2** months after group coverage ends
  - **Effective Date:**
  - Can choose an effective date up to 3 months in advance after receipt of election **but not** earlier than the first of the month following the month in which the request is made.
  - **Election Period:** Loss of Employer Group Coverage (Group Retiree, COBRA, and Commercial Coverage)
  - **Election Period Code: SEP – Loss of EGHP Coverage / LEC**

- **Medicare Supplement:** Client also has the option to take out a Medicare Supplement plan within **63 days.** Must be a Guarantee Issue plan.
- **Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- Client will need to provide proof of group coverage termination. This includes:
  - ✓ Group carrier name
  - ✓ Policy number
  - ✓ Client and/or Spouse's name
  - ✓ Policy Effective date
  - ✓ SPECIFIC Termination date. * See CCC information below
- ****Certificates of Credible Coverage (ccc)*** usually have all the information that is needed but are not provided to client until 30 days AFTER the group termination. ***Thus, if client will work with their HR department, the carrier will typically accept a Signed letter on Group letterhead, indicating the above needed information.***

****We suggest (if any way possible) to place client coming off Employer Group who already has Medicare Part A and B on a Medicare Supplement plan. This would be the ONLY WAY a client would have the option for a "Trial Period" under a MAPD plan.***

Client is Over 65 and has Medicare Part A and B. Decides to go to work and will Receive Employer Group Health coverage and thus decides to DROP Medicare Part B:

The client is NOW ready to leave the group coverage and needs Medicare Part B again (Client must be over 65 and on group of 20 or more employees):

- **Please call our office to discuss.**

General Enrollment Period (GEP) NEW as of 2023

(Late Medicare Part B Enrollment with NO Credible Coverage):

- General Enrollment Period sign up runs from **January 1st through March 31st.**
- A client may enroll during the Medicare General Enrollment period if:
  - **Client does Not have Credible coverage and did not enroll in Medicare Part A* and/or Part B when first eligible**
  - Client may sign up during this General Enrollment Period from January 1st through March 31st each year
  - Coverage will begin **the 1st day of the month following sign up. NEW as of 2023**
    - Sign up in January = February 1st effective date
    - Sign up in February = March 1st effective date
    - Sign up in March = April 1st effective
  - The client may have to pay a **HIGHER** Part A and/or Part B premium due to **Late Enrollment**

- **MA/MAPD:**
  - Client **MUST apply BEFORE the Medicare Part B effective date**
  - Client **does Not** have the option to take out MA/MAPD plan after their Medicare Part B has gone into effect.
  - **Enrollment Code: ICEP**
    - **Part B goes into effect on February 1 – must apply in January**
    - **Part B goes into effect on March 1 – must apply in February**
    - **Part B goes into effect on April 1 – must apply in March**

- **PDP:** There is NO SEP to enroll in a Prescription drug plan. (Unless client pays for Part A)

- **Medicare Supplement:**
  - Client has 6 months before **and** after Medicare Part B effective date to enroll in plans:
  - Eligible for Part A **On/or After** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
  - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
  - **There are a few** Medicare Supplement carriers who **apply a Pre-Existing clause** if client has not had credible coverage. Please refer to ***Medicare Supplement Cheat Sheets*** document for information.

.

RETROATIVE Effective Date - Client's Medicare Part A and B is Approved with Retroactive Start Date: *Most common – Under Age 65 Disability clients*

- Client will receive a **"*Notice of Entitlement*"** letter. The **Date of the letter** is the **trigger/start** date.
- **MA only:**
  - Client has month *"Notice of Entitlement"* is dated and **2** months after Date on the letter to enroll
  - Election Period: Retro Medicare Determination
  - Election Period Code: **Retro Medicare Determination** (MA only)
- **MAPD/PDP:**
  - Client has month *"Notice of Entitlement"* is dated and **3** months after Date on the letter to enroll
  - Election Period: Retro Medicare Determination
  - Election Period Code: **IEP (**MAPD/PDP)
- **Medicare Supplement:**
  - Client has 6 months from date on the "*Notice of Entitlement"* letter to enroll in any plan available:
    - Eligible for Part A **On/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
    - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**

Missouri Rx: Pharmacy Assistance Program Provided by the State:

- Client belongs to a pharmacy assistance program provided by their state. As of June 30, 2017, Missouri Rx only accepts **FULL DUAL** Medicaid and Medicare clients.
- **MAPD/PDP**:
  - One election per Calendar year
  - Effective date will be the 1st of the month following Receipt **and** Approval from the State
  - Client **MUST** have current Prescription Drug plan in force
  - Election Period: SPAP Members
  - Election Period Code: SEP-SPAP Enrollee (MAPD/PDP)
  - Missouri Rx is **NOT** considered Credible Coverage

Incarcerated Clients (Prison):

- Medicare generally does not pay for a client's health care while they are incarcerated. The Correctional Facility provides this coverage.
- If client has MAPD/PDP plan, they should stop paying premiums while incarcerated. No Part D penalty should accrue since they are not eligible to purchase a plan while inside.
  - Client **MUST** have continued to pay Medicare Part B premiums during their incarceration to be eligible for SEP enrollment upon release.
  - If client turns 65 while inside, they need to enroll in Medicare A and B.
  - If client **dropped** Medicare Part B, they would need to apply for Medicare Part B during General Enrollment (January 1st - March 31st for a possible February, March or April 1st effective date). Client may face Medicare Part B Late Enrollment penalty.
- If client **RETAINED** Medicare Part A and B, options are:
  - **MA/MAPD/PDP** enrollment Time Period begins; the month Before client is released and ends 2 months after client is no longer in custody.
  - Election Period: Change of Residence
  - Election Period Code: SEP-Change in Residence
- **Medicare Supplement**: This does NOT activate a Guarantee Issue Enrollment Period
- ***Best Scenario for client is***: *While incarcerated, client either **KEEPS** Medicare Part A and B or upon turning 65, ENROLLS in Medicare Part A and B.*

Client is on Medicare and Medicaid: (FULL or PARTIAL Spend Down):

- Client has both Medicare and Medicaid **OR** the state helps pay for their Medicare Premiums.
- **MA/MAPD/PDP** - Client may take out and/or change plans **ONCE during each of the FIRST 3 QUARTERS of the calendar year.**
  - Election Period: Dual-Eligible (Full Benefit and Partial)
  - Election Period Code: **SEP-Dual Eligible Full or Partial**

Example:

Mrs. Hurlbut has both Medicare and Medicaid and is covered on a MAPD plan with Company X. She has the option to change plans 1 time during:

✓ January, February, and March (February, March, and April Effective dates)
✓ April, May, and June (May, June, and July Effective dates)
✓ July, August, and September (August, September, and October Effective dates)

- **Medicare Supplement:** This does **NOT** activate a Guarantee Issue Enrollment Period.

Medicaid DROPS Client with Full or Partial Spend Down:

- Client no longer qualifies for both Medicare and Medicaid OR the state no longer helps pay for their Medicare premiums.
- **MA/MAPD/PDP Enrollment** begins, the month client is notified of **Loss of Dual Eligibility** and continues for 2 additional months *(**Date on Notification letter and 2 months after**)*
  - **One** Election per calendar year
  - Election Period: Dual-Eligible (Loss of Status)
  - Election Period Code: **SEP-Dual Eligible (Status Loss)**
- **Medicare Supplement:** A Client **CANNOT** go onto a Medicare Supplement in this situation **WITHOUT** going through Medical Underwriting.

Low-Income Subsidy (Extra Help/LIS) – (NON-MEDICAID):

- Eligible beneficiaries who have a limited income may qualify for a Government program that helps pay for Medicare Part D Prescription Drug coverage. Medicare beneficiaries (**not on Medicaid**) receiving **Low-Income Subsidy (LIS)** receive assistance paying for their Part D monthly premium, annual deductible, co-insurance, and co-payments.
- **MAPD/PDP:**
  - Effective date will be 1st of the month following Receipt of Election (**Date on letter**)
  - Client may take out and/or change plans ***ONCE* during each of the first 3 quarters of the calendar year**
  - Election Period: LIS (Non-Medicaid and Maintaining LIS)
  - Election Period Code: **SEP-LIS (Non-Medicaid/Maintaining LIS)**

Client NO longer qualifies for "Extra Help" to pay for Medicare Prescription drugs:

- **MAPD/PDP**
  - Client has a **One-time** SEP to Dis-enroll from OR switch their MAPD/PDP plan
  - Begins when client is notified of the Loss and ends 2 months after notification (Month of and 2 months after)
  - Election Period Code: LIS (Loss of Status)

CMS AUTO-ENROLLMENT of Medicare Advantage or Prescription Drug Plan

- Clients who automatically qualify for Extra Help will receive a letter stating, **"You're being enrolled in a Medicare Drug Plan"**
  - **YELLOW or GREEN letter** – means they qualify for Medicare and Medicaid AND currently get benefits through Original Medicare.
  - **PURPLE letter** – means they qualify because of any of the following: Client has both Medicare and Medicaid, Client is in Medicare Savings Program, or client receives Supplemental Security Income (SSI) benefits.
- **The plan chosen for a client, must ALWAYS have a monthly premium LESS than the LIS Subsidy amount and is completely random.**
- Letter should indicate:
  - Client is being enrolled in a Rx plan with a certain Carrier / Plan and Effective Date
  - Premium amount, Deductible amount, and LIS Co-Pay level
  - Company phone number to discuss questions or needs
  - It will list out other carrier's Extra Help plans client has option to enroll in.
- **MA plan:** If the client enrolls in a PFFS plan **WITHOUT** drug coverage, Medicaid will automatically enroll the client in a PDP plan.
- **MAPD plan:** If the client enrolls in a MAPD plan, this satisfies the Medicaid Rx requirements.
- Available Medicare Drug Plans **differ per STATE.** Call anytime for details or a copy of sample client letters.
- Client has the right to take out Prescription Drug plan coverage of their own election. **They do not have to stay on the plan they are automatically enrolled** in through Medicaid.

You as agent, can enroll a client in this situation.

2023 – Extra Help Medicare Drug Plans in Missouri

WellCare	WellCare Classic (PDP)
Aetna Medicare	SilverScript Choice (PDP)
Cigna	Cigna Secure Rx (PDP)
Humana	Humana Basic Rx Plan (PDP)
Clear Spring Health	Clear Spring Health Value Rx (PDP)

Nursing Home (Institutionalized):

- **Nursing Home Enrollment Definition:** Client moves into, resides in, or moves out of a Long Term Care Facility (Skilled Nursing Facility (SNF), Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Hospital/Unit, Rehabilitation Hospital/Unit, Long-Term Care (LTC) Hospital or Swing Bed Hospital (with an expected stay of at least 90 days.)
- **MA/MAPD/PDP:**
  - Client has Continuous Elections. May take out and/or change MA/MAPD/PDP plans any time of the year
  - Starts the 1st day client goes **into** Facility and ends **2** months after **discharge**
  - Effective date will be the 1st of the month following receipt of election
  - Client may enroll when:
  - **GOING into facility**
  - **RESIDING in facility**
  - **LEAVING facility**
  - Election Period: Institutionalized
  - **MA/MAPD** Election Period Code: **OEPI**
  - **PDP** Election Period Code: **SEP-Institutional**

Client is currently Covered under MA/MAPD/PDP plan. They have a Change of Residence and Move out of Service Area:

- ***MA/MAPD/PDP:*** To obtain another plan, enrollment Timeline follows:
  - **BEFORE** the Move: SEP begins the month BEFORE permanent move and ends 2 months after the move.
  - **AFTER** the Move: SEP begins the month client Notifies the Carrier OR the month client was terminated by their current plan due to residing outside of the service area. Ends 2 months after notification of move OR after notification of Plan termination.
  - Election Period: Change of Residence
  - Election Period Code: **SEP-Change of Residence**
- **Medicare Supplement:** Client may enroll in Medicare Supplement plan within 63 days of the current MA or MAPD plan's termination. Must be a **Guarantee** Issue Plan. Plans available:
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- **As a general rule, client will need to submit the letter they receive from MA/MAPD carrier indicating the termination date of the plan. MUST show a SPECIFIC Term date.**

Client is Covered under MA/MAPD/PDP plan. They have a Change of Residence BUT DO NOT Move out of Current Service Area:

- **IF** the new location has **Additional** MA/MAPD/PDP plans available to client, an SEP is available for client **to enroll in one of the Additional plans**:
- **MA/MAPD/PDP** to obtain another plan, enrollment Timeline follows:
  - **BEFORE** the Move: SEP begins; month BEFORE permanent move and ends 2 months after the move.
  - **AFTER** the Move: SEP begins; month the client Notifies the Carrier OR month the member was terminated by their current Carrier due to residing outside of their service area. Ends 2 months after notification of move OR after notification of Plan termination.
  - Election Period: Change of Residence
  - Election Period Code: **SEP-Change of Residence**
- **Medicare Supplement**: No Guarantee Issue to write.
- **BUT, in this same situation**, if client was covered under a Medicare Supplement plan and changed residence (but not out of current Service area) and new location has **Additional MA/MAPD plans** available; Client **can come off Medicare Supplement plan and go onto a MA/MAPD plan**. **SEP-Change of Residence**

MA/MAPD/PDP Plan is no longer offered in Client's area. "Non-Renewing":

- Carriers should notify clients covered under *"Non-Renewing"* MA/MAPD/ PDP plans by September 30th. Letter will indicate their plan will not be offered as of January 1st of the following year.
- Client has from **December 8th through the last day of February of the following year** to enroll in another MA/MAPD/PDP plan. (This is in ADDITION to AEP – October 15th through December 7th).
  - Enrollments made October 15th - December 31st will be effective January 1st.
  - Enrollments made in January will be effective February 1st.
  - Enrollments made in February will be effective March 1st.
- **MA / MAPD / PDP:**
  - Election Period: Non-Renewing
  - Election Period Code: **SEP-Contract Termination**
- **Medicare Supplement:**
- Client has option of moving to a Guarantee Issue Medicare Supplement plan with effective date options of January 1st **through** March 1st.
- If writing Medicare Supplement Plan, you would also want to write **Stand-Alone PDP Plan**.**
  - ***Note:** As indicated, client has option to take **Medicare Supplement** plan for **any available effective date** between January 1st and March 1st. Prescription Drug Plans (PDP) **ALWAYS** have **1st of the month effective dates**. Please keep this in mind as you are helping client.
  - Plans Available:
    - Client Eligible for Medicare Part A O**n/or after** January 1, 2020 - ***Plans A, B, D, G, K, L***
    - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

- ***Suggestion:*** **Many times, agents will WAIT and schedule client appointments until after December 7th, the end of Annual Enrollment. You will still have time to meet the client's needs for a January 1st effective date.**

- **If you do write between October 15 and December 7th, you must use AEP enrollment code, NOT SEP code.**

Medicare Advantage Special Needs Plan (SNP):

- If client has a Qualifying Chronic Condition, they may enroll in a Medicare Advantage Special Needs Plan **(SNP).**
- **MA/MAPD:**
  - Client has **annual 1-time** Special Enrollment Period (SEP)
  - If client has multiple Qualifying Chronic Conditions, they are allowed a Special Enrollment Period one time annually **- PER chronic condition**
  - Election Period: Chronic Condition
  - Election Period Code: **SEP-Special Needs/Chronic**

Client is being "Dis-Enrolled" from their CHRONIC Special Needs Plan (SNP) due to Non-Verification of Chronic Condition:

- Often this occurs when a doctor does not respond to the carriers request for Verification of client's Chronic condition.
- **MAPD / PFFS-MA only / PDP**:
  - Client may join a MAPD / PFFS-MA only (a PDP plan **must also** be written) / PDP
  - Timeline begins:
  - Month of effective date of disenrollment
  - Ends 3 months After the date of involuntary disenrollment
- ***NOTE: Client's current plan MUST continue to cover client for at least one month when they become ineligible, and for up to 6 months, if it is likely they will Re-qualify within the 6-month period.***
  - Election Period: Chronic SNP Non-Eligibility
  - Election Period Code: **SEP-Loss of SNP status**
- **Medicare Supplement**: This does **NOT** activate a Guarantee Issue Enrollment Period.

Section 3 MEDIGAP – *aka* - MEDICARE SUPPLEMENTS

MEDIGAP - Highlights and Agent Tips

- A Medicare Supplement / Medigap policy is Private health insurance that helps supplement Original Medicare.
- They are designed to help pay some of the health care costs that Original Medicare does not cover (example: Co-payments, Co-insurance & Deductibles). These are known as "Gaps" in Original Medicare coverage. Medicare will pay its share of the Medicare Approved Amounts for covered health care costs. Medicare will not pay any portion of the Medicare Supplement premium.
- Client **MUST** have Medicare Part A and Part B to buy a Medicare Supplement policy.
- Standard Medicare Supplements have **NO Provider Networks**. Clients may go to any Provider/Facility if they accept Original Medicare.
- There are **4 basic ways to enroll** in a Medicare Supplement.
  - Open Enrollment
  - Missouri Anniversary
  - Guarantee Issue
  - Going through Underwriting
- **Open Enrollment** (some refer to as Initial enrollment). Federal guidelines indicate a client has **6 months Before and After** the following scenarios to take out a Medicare Supplement with no underwriting (Please refer to our **Medicare Cheat Sheets** for **tobacco "*lifestyle"*** exception):
  - Turning 65 and going onto Medicare Part A and B
  - Already on Medicare Part A and B and turning 65
  - Delayed Medicare Part B and takes out later
- The effective date cannot be before the Medicare Part B effective date OR the 1st day of the 65th birthday month (if already on Medicare Part A and B and aging in). There are a few carriers who **do not accept these rules** and have **different/shorter** enrollment timeline. Please refer to out ***Medicare Cheat Sheets*** for additional information.
- Agent must be **Licensed** in the state and **Appointed** with the carrier where application is written. Agent does NOT have to take AHIP or certify with carriers to write Medicare Supplements.

EXCEPTION: UHC/ AARP: to write an AARP Medicare supplement plan, AGENT must take AHIP (or UHC's internal AHIP) and Certify with UHC. Please call our office and we can help get you started.

- Client pays a **premium** to a Private Insurance company for their Medicare Supplement policy, in ADDITION to their monthly Part B premium they pay to Medicare.
- **Premium Payments**: **How a client pays** their premium and by **what method** differs per carrier. Please refer to out ***Medicare Cheat Sheets*** for additional information.
- **Cancellation**:
  - Non-Payment of Premium – The carrier must give client 30 days to pay late premium (Grace Period)
  - Client Passes Away – The carrier will need to be notified of death. Most will want a copy of Obituary or Death Certificate.
- **Medicare Part A, B, C, D vs Medicare Supplement Plans A, B, C, D**:
- We advise making sure your clients understand the **difference** between **Medicare Part** A, B, C, D and **Medicare Supplement Plans** A, B, C & D.

- In working with different scenarios with Medicare Supplements, keep in mind, **certain enrollments <u>TRUMP/OVERRIDE everything</u>**. For example:
- **<u>Working past 65 and DELAYED Medicare Part B</u>**: Client comes off Employer Group and goes onto Medicare Part B for the 1st time. **Medicare Part B Trumps/Overrides** the Group, so you would use Medicare Part B enrollment rules. (Client able to enroll in any plan available to them)
- **<u>Client is already on a Medicare Supplement and turns 65:</u> Turning 65 Trumps/Overrides** everything at this time, so you would use Turning 65 enrollment rules. (Client able to enroll in any plan available to them)
- **Client wants to Stay on Original Medicare with no other Supplemental Plan Coverage****
  - A client does not have to take out any supplemental/gap coverage.
  - BUT make sure that client realizes, they would **<u>NOT have a ceiling for their claims</u>**. <u>They WOULD be responsible for:</u>
    - Medicare Part A deductible and co-pays
    - Medicare Part B deductible and 20% co-insurance of all Medicare Part B covered services.

NOTE: We suggest, at least trying to place a Medicare Advantage plan on your client OR to have client sign a waiver indicating they understand what their possible Out of Pocket costs could be. (We have waiver form available)

Medicare Supplement - Highlights, Plan Basics and Agent Tips, continued:

There are 3 Types of Medicare Supplement Policy Ratings -Missouri is an ISSUE-AGE Rated state

- **Issue-age Rated - The premium is based on the age of the applicant when the Medicare Supplement policy is purchased. Premiums are lower for applicants who buy at a younger age and will not change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.**
- **Attained-age Rated -** The premium is based on the applicant's current age, so the premium goes up as the applicant gets older. Premiums are lower for younger buyers but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.
- **Community Rated -** The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.

Covered Under Medicare Advantage (MA/MAPD) and Medicare Supplement plan at the Same Time:

- Client has a current MAPD plan. It is **<u>ILLEGAL</u>** for anyone to sell a Med Supp policy to client unless they are switching to Original Medicare and taking out a stand-alone PDP plan.
- Client has a current Medicare Supplement plan and **joins** a MAPD plan **<u>without</u>** canceling their Medicare Supplement plan.
- *We do **<u>NOT</u** recommend.* The MAPD plan pays the client's approved claims. The Medicare Supplement plan will pay **NOTHING** because the client **<u>IS NO LONGER</u>** on Original Medicare
- Any <u>Standardized</u> Med Supp plan is <u>Guaranteed Renewable</u> if premiums are paid.

PART B EXCESS CHARGES:

- Most Doctors and Providers who accept Medicare patients, also accept the *"Assigned"* Medicare rate for their services. Other Doctors/Providers may charge a higher rate for their services. This charge can be **NO MORE** than **15% above** the Medicare assigned rate. If over, Medicare will **NOT** reimburse the Doctor/Provider and client is **NOT** responsible.

Example:

Medicare determines and assigns the ***Fair & Reasonable service rate*** for an **allowable procedure** is $1,000.00.

A: The Doctor/Provider who accepts Medicare Assignments would bill Medicare at the $1,000.00 service rate or below.

B: Another Doctor/Provider decides $1,000.00 is not enough to cover their service for the same procedure. They can charge up to an additional 15% above the $1,000.00 Medicare Assigned Service Rate.

In this example:

- Options A: Medicare would pay Doctor/Provider 80%, client would be responsible for 20%.
- Option B: The Doctor/Provider would charge Medicare $1,150.00. Medicare would reimburse $800.00 to the Doctor/Provider. Client is already responsible for 20% ($200) and now would be **responsible for the 15% OVERAGE of $150.00**. Client total responsibility $350.00.

Ways for your client to AVOID Medicare Part B Excess Charges:

- **Purchase** a Medicare Supplement policy that **covers Medicare Part B Excess Charges.**

Eligible for Part A **On/or After** January 1, 2020: **Plan G**
Eligible for Part A **Prior to** January 1, 2020: **Plan F or G**

- **Choose Doctors/Providers** who will bill their services at the assigned Medicare rate.
- **Ask their Doctors/Providers** if they use **"BALANCE BILLING"** (if they charge Medicare Part B excess charges). Client then has option to either accept possible responsibility for additional charges OR find a new Doctor/Provider.
- Medicare.gov has a database that *"attempts"* to track and list Doctors/Providers that use Balance Billing. (https://www.medicare.gov/physiciancompare/search.html)

- ***Note: Recent studies have shown Medicare Part B excess charges have greatly reduced*** *in the last few years for General Practitioners.* ***Situations still seeing a higher incidence of Part B excess charges are visits to a SPECIALTIST and OUT-PATIENT SURGERIES.***

Benefit Coordination and Recovery Center

- Occasionally, a client will discover **Medicare's system does not reflect the current Carrier/Product a client is covered under.**

Example:

  - Medicare Supplement replacement - Carrier A is replaced with Carrier B, but Medicare still reflects Carrier A or
  - Client comes off a Group plan takes out other coverage, and Medicare still reflects the Group coverage.

- Most common situations:
  - When a client goes to a Pharmacy after coming off their Group plan. The client presents their PDP/MAPD id card and Pharmacy indicates client is covered under their group plan
  - When a client's Medicare Supplement claims are denied due to no coverage with the carrier

- If this occurs, the client needs to reach out to the ***Benefits Coordination and Recovery Center***. This is a 3rd party organization that helps Medicare know what carrier is primary on each beneficiary and works to update Medicare's system.
- **Phone number: 855-798-2627. They will ask the client to supply details about their previous and replaced coverage, including dates of coverage.**

Medicare Supplement Plans and Foreign TRAVEL

- Medicare usually **does not** cover health care while client is traveling outside the United States. **(Note - The 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the U.S.)** There are some exceptions, including some cases where Medicare Part B (Medical Insurance) may pay for services that a client receives on board a ship within the territorial waters adjoining the land areas of the U.S. Complete details may be found at www.Medicare.gov.

- **Some Medicare Supplement insurance plans may cover client when they travel outside the U.S.**
- If client has Medicare Supplement Plan C, D, E, F, G, H, I, J, M or N, their plan:
  - Covers foreign travel emergency care if it begins during the first 60 days of their trip, and if Medicare does not otherwise cover the care.
  - Pays 80% of the billed charges for certain medically necessary emergency care outside the U.S. after they meet a $250 deductible for the year.
  - Foreign travel emergency coverage with Medigap policies has a **lifetime limit of $50,000**.

- **Suggested articles to read and share with your clients from CMS Publications:**
  - ***"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"***
  - ***"Medicare and You"***
  - ***"Medicare Supplemental Insurance: Getting Started"***
  - ***"Medicare and Other Health Benefits: Your Guide to Who Pays 1st"***

Timeline History of Medicare Supplements:

- **Before July 1992 – Pre-Standardized Medicare Supplements:**
  - Before 1992 Medicare Supplements were NOT Standardized
  - Policies were regulated by Individual States
  - Companies could create whatever type of plan they wished to market. According to a report by the Office of Inspector General for the U.S. Department of Health & Human Services (HHS), the lack of Federal oversight in the industry allowed for marketing fraud & consumer abuse.
  - ***Note:*** You will still find a few clients that have remained on a Pre-Standardized Medicare Supplement plan, Their ONLY option to change plans is to go through medical underwriting.
- **1980 – 1990: Implementing the Omnibus Budget Reconciliation Act (OBRA) of 1990:**
  - Between 1980 – 1990 the Federal and State Governments, with the National Association of Insurance Commissioners (NAIC) worked together to implement the *OBRA* Act
  - Going forward, this Reform legislation; Standardized Medicare Supplements, Prohibited the sale of any Pre-Standardized plans and established Consumer Protection.
- **1992: Standardized Medicare Supplements:**
  - At this time, all carriers MUST offer the same benefits as defined by their plan type.
  - Insurance carriers may NOT offer more than 10 different plans
  - Plans to be offered: A, B, C, D, E, F, G, H, I, J (H, I, J offer Prescription Drug benefits)
- **1998: High Deductible Plan Options Added:**
  - High Deductible Plans F and J were added
  - A deductible must be paid by client before either plan would start to pay benefits
- **2003: The Medicare Prescription Drug Improvement and Modernization Act:**
  - This Act established:
    - The first steps toward the creation of the Medicare Part D (Rx) Plans in 2006
    - Standardized H, I, J plans could no longer offer Prescription Drug coverage
    - Plans K and L were introduced as the 1st Cost Sharing plans
- **2010: MODERNIZATION of Medicare Supplement Plans:**
  - Due to Expanding Benefits under Medicare:
    - Plans E, H, I, J and High Deductible J, are discontinued for new sale
    - Plans M & N are introduced. These plans offer a type of Cost Sharing (like Plans K and L). Plan N offers a Flat Dollar Co-Pay.
- **2015: MACRA – The Medicare Access, and CHIP Reauthorization Act:**
  - As of 2020 Medicare Supplement plans sold to **Newly Eligible Medicare Enrollees** (going onto Medicare Part A **On/or After January 1, 2020),** may No Longer offer **1st Dollar Coverage** (covering the Medicare Part B deductible).
    - For more details, refer to MACRA info in Resource Center
- **2020: Implementation of The Medicare Access, and CHIP Reauthorization Act:**
  - **Changes effective January 1, 2020:**
    - Clients **Newly eligible** for Medicare Part A **ON/OR AFTER** January 1, 2020, are **NO LONGER** able to purchase Medicare Supplement plans C, F and High Deductible F (HDF).
    - Clients who have Medicare Part A **PRIOR** to January 1, 2020, can **RETAIN or PURCHASE** Medicare Supplement plans C, F and High Deductible F (HDF).
    - **High Deductible Plan G is added**. Available to all Medicare eligible persons

ALL Medicare Supplement Plans Available:

- Eligible for Part A **On/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
- Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
  - **Missouri Anniversary** is *"Business as Usual".* Client may switch Same Plan to Same Plan during this time.
  - **Guarantee Issue Enrollment:** Plans change for Newly eligible for Medicare Part A On/or After January 1, 2020.
- **Guarantee Issue Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

Medicare Supplement Highlights & Plans Available

- **ALL PLANS**
  - **Clients eligible for Medicare Part A *On/or AFTER* 1-1-2020:**
    - **A, B, D, G*, K, L, M, N** *High Deductible G (HDG)
  - **Clients eligible for Medicare Part A *PRIOR* to 1-1-2020:**
    - **A, B, C, D, F*, G*, K, L, M, N ***High Deductible F and G (HDF & HDG)
- **GUARANTEE ISSUE PLANS**
  - **Clients Eligible for Medicare Part A *On/or AFTER* January 1, 2020:**
    - ***Plans A, B, D, G, K, L***
  - **Clients Eligible for Medicare Part A *Prior to* January 1, 2020:**
    - ***Plans A, B, C, F, K, L***

Medicare Supplement Benefits	A	B	C[1]	D	F[1,2]	G[2]	K[3]	L	M	N[4]
Part A coinsurance and hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
First 3 pints of blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care co-insurance or co-payment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Co-insurance for skilled nursing facility			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B deductible			✓		✓					
Medicare Part B excess charges					✓	✓				
Foreign travel emergency			80%	80%	80%	80%			80%	80%

1. Plans C and F are not available to new beneficiaries who became eligible for Medicare on or after January 1, 2020.
2. Plans F and G also offer a high deductible plan which has an annual deductible of $2,700 in 2023. Once the annual deductible is met, the plan pays 100% of covered services for the rest of the year. The high deductible Plan F is not available to new beneficiaries who became eligible for Medicare on or after January 1, 2020.
3. Plan K has an out-of-pocket yearly limit of $6,940 in 2023. Plan L has an out-of-pocket yearly limit of $3,470 in 2023.
4. Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to $50 for emergency room visits that don't result in an inpatient admission.

ALL Medicare Supplement plans MUST Cover the following basic benefits:

- Hospitalization: Part A Co-insurance and hospital costs
- Medical Expenses: Part B Co-insurance (generally 20% of Medicare-approved expenses) or Co-payments for hospital outpatient services. Plans K, L and N require insured beneficiaries to pay a portion of Part B co-insurance or co-payments
- Blood: First 3 pints of blood each year
- Hospice: Part A Co-insurance and respite care expenses (including applicable prescription Co-payments)

Medicare Supplement PLAN "A" - (Different from Medicare "Part" A):

- Covers the fewest benefits of all the plans
- Premiums are typically low, but has potential to incur **high** "Out of Pocket" Expenses
- **Available** to **All Medicare eligible clients**
- Included as **plan choice on Guarantee Issue (GI) plan list – see below:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- Rare to have a client on a Plan "A"

Medicare Supplement PLAN "B"(Different from Medicare "Part" B):

- Plan B does cover Medicare Part A deductible, but still leaves MANY "Gaps"
- **Available** to **All Medicare eligible clients**
- Included as plan choice **on Guarantee Issue (GI) plan list – see below:**
  - Client Eligible for Medicare Part A O**n/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

Medicare Supplement PLAN "C"(Different from Medicare "Part" C)

- Plan covers MOST Medicare approved "Out-of-Pocket" expenses
- **NOT Available** to clients Eligible for Part A **On/or** after January 1, 2020.
- Does Not cover Medicare Part B excess charges
- Foreign Travel Emergency **IS** covered (80%)
- Included as plan choice **on Guarantee Issue (GI) plan list – *ONLY* for clients eligible for Medicare Part A Prior to** January 1, 2020

Medicare Supplement PLAN "D" (Different from Medicare "Part" D)

- Plan D coverages come in midway of the 10 plans
- Foreign Travel Emergency **IS** covered (80%)
- Plan does **NOT** cover Part B deductible or Part B Excess Charges
- **Available** to **All Medicare eligible clients**
- Included as plan choice **on Guarantee Issue (GI) plan list – *ONLY* for clients eligible for Medicare Part A Prior to** January 1, 2020

Medicare Supplement PLAN "F":

- Plan F offers the most **Comprehensive** coverage of the 10 plans available
- **NOT Available** to clients Eligible for Part A **On/or** after January 1, 2020.
- Foreign Travel Emergency **IS** covered (80%)
- ***Medicare Part B Deductible*** IS covered
- **Medicare Part B Excess Charges** ARE covered
- **Included as Guarantee Issue (GI) plan list:**
  - **AVAILABLE to Clients Eligible for Medicare Part A PRIOR to January 1, 2020.**
  - **NOT Available** to clients Eligible for Part A **On/or** after January 1, 2020.

Medicare Supplement PLAN "High Deductible F (HDF)":

- Plan has **CALENDAR** Year Deductible, then offers **SAME** benefits as a Standard F plan
- Part B deductible **applies toward plan deductible**
- 2023 **deductible** $2,700.00
- **How the plan works**: For Medicare approved services, client pays the Deductible (Co-payments, Co-insurance). Once the plan deductible is met, the plan pays at 100% of covered services for rest of Calendar Year.
- The deductible resets each year on January 1st
- Typically, premium will be very low ***(FYI – Premium = Commission)***
- Foreign Travel Emergency **IS** covered (80%)
- **ONLY** available to purchase by clients who enrolled in Medicare Part A **PRIOR** to January 1, 2020.
- Clients eligible for Part A on/or after January 1, 2020, **DO NOT** have the option to purchase this plan.

Medicare Supplement PLAN "G":

- Plan G offers **comprehensive** coverage
- **Does NOT cover Medicare Part B deductible. Client is responsible to pay** their Medicare Part B deductible
- Foreign Travel Emergency **IS** covered (80%)
- Medicare Part B Excess Charges **ARE** covered
- **Available** to **All Medicare eligible clients**
- **Included as Guarantee Issue (GI) plan list:**
  - **AVAILABLE to Clients Eligible for Medicare Part A On/or After January 1, 2020.**
  - **NOT Available** to clients Eligible for Part A **PRIOR** to January 1, 2020.

Medicare Supplement PLAN "High Deductible G (HDG)":

- Has a **CALENDAR** Year Deductible, then offers **SAME** benefits as a Standard G plan
- Part B deductible **applies toward plan deductible**
- 2023 – Medicare Part B deductible $2,70.00
- Foreign Travel Emergency **IS** covered (80%)
- **Medicare Part B Excess Charges** ARE covered
- **How the plan works:** For Medicare approved services, client pays the Deductible (Medicare Part B deductible, Co-payment, and Co-insurance). Once the plan deductible is met, the plan pays 100% of covered services for rest of Calendar Year.
- The deductible resets each year on January 1st
- Typically, premium will be lower ***(FYI – Premium = Commission)***
- **Available** to **All Medicare eligible clients**

Medicare Supplement PLAN "K":

- This plan pays a percentage (50%) for almost all covered benefits
- Plan has Calendar year "**Out of Pocket**" cap. Resets annually on January 1st.
- **2023 $ 6,940.00 Out of Pocket**
- Once "Out of Pocket" cap is met, plan pays 100% of Medicare covered services for rest of calendar year.
- **Does Not include** Medicare Part B Excess charges or foreign travel emergency
- Premiums tend to be lower due to client's higher "Out-of-Pocket" exposure
- **Available** to **All Medicare eligible clients**
- Included as plan choice on **Guarantee Issue (GI) for all Medicare eligible clients**

Medicare Supplement PLAN "L":

- This plan resembles Plan K.
- Main difference between Plans K and L are:
  - This is a richer plan
  - LESS "Out of Pocket" exposure (half of Plan K) and covered Benefit percentage is HIGHER than plan K
- Pays a percentage (75%) for almost all covered benefits
- Plan has Calendar year "**Out of Pocket**" cap. Resets annually on January 1st.
- **2023 - $ 3,470 Out of Pocket**
- Once "Out of Pocket" cap is met, plan pays 100% of Medicare covered services for rest of calendar year.
- **Does Not cover** Medicare Part B Excess charges or foreign travel emergency
- **Available** to **All Medicare eligible clients**
- Included as plan choice on **Guarantee Issue (GI) for all Medicare eligible clients**

Medicare Supplement PLAN "M":

- All Medicare "Basic Benefits" are fully covered
- Plan covers 50% of Medicare Part A deductible.
- Plan does cover foreign travel emergency.
- **Does Not cover** Medicare Part B Deductible or Excess charges
- **Available** to **All Medicare eligible clients**

Medicare Supplement PLAN "N":

- This plan pays 100% of the Part B coinsurance. **EXCEPT** for
  - A Co-payment of up to $20 for some office visits
  - A Co-payment of up to $50 for each Emergency room visit **(waived if admitted as inpatient**)
- Plan **DOES** cover foreign travel emergency at 80%
- **Plan does Not cover** Medicare Part B Deductible or Excess charge
- **Available** to **All Medicare eligible clients**

Plan N was introduced in 2010 and you likely will see this plan "pop up" occasionally. Initially, most carriers offered this with few underwriting questions and low premiums. Thus, many policies were sold. The current N plans still reflect low premiums, but clients are now fully vetted through medical underwriting.

MEDICARE SUPPLEMENT - Common ENROLLMENT PERIODS & SCENARIOS

OPEN / INTIAL Enrollment:

- During the Open Enrollment time period (often referred to as Open or **Initial** enrollment), client may **enroll in any** available Medicare Supplement plan with **NO underwriting.**
- Open enrollment applies to anyone who is:
  - **Turning 65 and Receiving Medicare Part B for the 1st time**
  - **Turning 65 (already covered on Part B)**
  - **Over 65 and Receiving Part B for the 1st time (Delayed Part B)**
- **Plans Available:**
  - Eligible for **Part A On/or After** January 1, 2020
    - **Plans A, B, D, G, HDG, K, L, M, N**
  - Eligible for **Part A Prior to** January 1, 2020
    - **Plans A, B, C, D, F, HDF, G, HDG, K, L, M, N**
- ***NOTE:*** There are a few Medicare Supplement carriers who **apply a Pre-Existing clause** if client has not had credible coverage. Please refer to ***Medicare Supplement Cheat Sheets*** document for information.

GUARANTEE ISSUE:

- A client has 63 days to enroll in a Medicare Supplement plan when they first qualify for Guarantee Issue enrollment.
- There are **SPECIFIC Guarantee Issue Plans a client must choose from**.
- As of January 1, 2020, we now have **2 separate Guarantee Issue Plan Lists** based on client's enrollment in Medicare Part A.

Most common scenarios for Guarantee Issue enrollment:

- **Coming off Employer / Union group coverage**
- **Coming off Medicare Advantage Plan *(plan terminating/non-renewal)***
- **Guarantee Issue Plans available:**
  - Client Eligible for Medicare **Part A On/or After** January 1, 2020
    - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare **Part A Prior to** January 1, 2020
    - ***Plans A, B, C, F, K, L***
- **Medicare Supplement – Common Enrollment Periods continued: Guarantee Issue**

Coming off Employer / Union group coverage

- **Missouri accepts Involuntary and Voluntary Group Terminations**
- Client will need to provide Proof of coming off Group plan. Must show client has been covered under credible Employer Group coverage, including:
  - ✓ Clients and/or Spouse's name
  - ✓ Group name
  - ✓ Policy #
  - ✓ Effective date
  - ✓ Termination date.
- ***Note:*** **Certificates of Credible Coverage (ccc)** usually have all the information that is needed but are not provided to client until 30 days after the group termination. ***Thus, the carrier will typically accept a Signed letter on Group letterhead, indicating the above needed info.***

Coming off Medicare Advantage Plan *(plan terminating/non-renewal)*

- Client will need to submit Termination letter received from Medicare Advantage (MAPD) carrier. **It must state a specific Termination date.**

MISSOURI ANNIVERSARY:

- Clients currently covered by a Medicare Supplement plan **may Review and Change** their carrier (typically to obtain better Premium Rate and/or Rate Guarantee) once a year.
- Plans must be **SAME** plan type. Example: Plan *F* to *F – G* to *G*
- **No Underwriting** Exception: A few carriers consider TOBACCO a "***Lifestyle***" and client must answer the Tobacco question. If "Yes" answer, tobacco will be applied. ******
- **Effective date MUST be within 30 days** front and back of current Med Supp effective date. (Standard industry accepts a month with 31 days, the same as a month with 30 days)
- **Client must provide documentation** of their prior coverage including Plan Type, Effective Date, Carrier Name, Client Name, Policy Number and Paid to Date
- We have **samples of Post Cards or Letters** to send to client's during this time period. Call our office and we can help!
- ****** Refer to our ***Medicare Supplement Cheat Sheets*** document for details.

MEDICAL UNDERWRITING:

- Common Reasons for applying through Medical Underwriting:
  - Client wishes to be Covered under a different Plan Type
  - Less premium and client is outside of Missouri Anniversary timeframe
  - Do not have a current Medicare Supplement policy
- When going through underwriting, **all the medical questions must be answered**. If client answers **Yes** to a question, many times the application will tell you upfront if application can be submitted or if it will be an automatic decline.
- We are here to help you Pre-Screen you clients and answer your questions!

Client Newly Eligible for Medicare (Getting Part A & B for 1st time):

- Client may take:
  - **MEDICARE SUPPLEMENT**:
    - Plans Offered:
      - A, B, D, G, High Deductible G (HDG), K, L M and N
      - Carriers often vary in plans they offer.
    - May apply 6 months front and back of Medicare Part B effective date
    - Effective date must be ON or AFTER client's Medicare Part B effective date
- ***NOTE:*** When client is newly enrolled in Medicare Part A and B, if desired, they may submit and withdraw/cancel a Med Supp policy to change to a different plan or even carrier. **LAST** application is what client will be covered under.

Example: Client is newly covered under Medicare Part A and B on August 1st. You write your client a Plan "G" with an 8-1 effective date. A month or so down the road, the client decides they want a plan "L". You would need to write the plan "L" with the desired carrier and cancel plan "G" policy. **You will need to pick up a Replacement form.**

- **Stand Alone PDP:**
  - Effective date cannot be before Medicare **Part A** effective date.
  - May apply 3 months before, month of and 3 months after
  - Election Period: Newly Eligible
  - Election Period Code: IEP

- **MA/MAPD:**
  - Effective date cannot be before Medicare Part A and B effective date.
  - Alternative option to Medicare Supplement. May apply 3 months before, month of and 3 months after.
  - Election Period: Newly Eligible
  - **MA Only**: Initial Period Code: ICEP
  - **MAPD:** Initial Period Code: IEP

Turning 65 ALREDY enrolled in Medicare Part A and B:

- Client was eligible for Medicare Previously but has recently turned 65. "Aging In"
- They have option of enrolling in:
  - **MEDICARE SUPPLEMENT**:
    - Plans offered:
      - Eligible for Part A **On/or after** January 1, 2020
        Plans A, B, D, G, HDG, K, L, M, N
      - Eligible for Part A **Prior to** January 1, 2020
        Plans A, B, C, D, F, HDF, G, HDG, K, L, M, N
- Apply 6 months Front and Back of clients **65th Birthday**

PDP:

- May apply 3 months before, month of and 3 months after clients **65th birthday month**. Effective date cannot be before 65th birthday month.
- Election Period: Age-In (Eligible Prior to Age 65)
- Election Period Code: IEP2

MAPD:

- Alternate option to Medicare Supplement. May apply 3 months before, month of and 3 months after. Effective date cannot be before clients **65th birthday month.**
- Election Period: Age-In (Eligible Prior to Age 65)
- Election Period Code: IEP2

- ***NOTE: If client has accrued a PDP Late Enrollment Penalty, the penalty is wiped clean!***

Working past 65 Client and Coming Off Employer or Union Qualified Group Plan, ALREADY "Enrolled" in Medicare Part A and B:

- **Medicare Supplement:** Client also has the option to take out a Medicare Supplement plan within **63 days.** Must be a Guarantee Issue plan.
- **Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
  - Client will need to provide proof of group coverage termination. This includes:
    - ✓ Group carrier name
    - ✓ Policy number
    - ✓ Client and/or Spouse's name
    - ✓ Policy Effective date
    - ✓ SPECIFIC Termination date. * See CCC information below

*__***Certificates of Credible Coverage (ccc)***__ usually have all the information that is needed but are not provided to client until 30 days AFTER the group termination. __***Thus, if client will work with their HR department, the carrier will typically accept a Signed letter on Group letterhead, indicating the above needed information.***__

******We suggest (if any way possible) to place client coming off Employer Group who __already__ has Medicare Part A and B on a __Medicare Supplement plan__. This would be the ONLY WAY a client would have the option for a "Trial Period" under a MAPD plan.***

- __MA/MAPD/PDP__ **Time Frame, Effective Date and Enrollment Code:*****
  - **Time Frame**:
    - **Begins** month group allows for disenrollment **OR** date COBRA ends.
    - **Ends 2** months after group coverage ends
  - **Effective Date:**
    - Can choose an effective date up to 3 months in advance after receipt of election **but not** earlier than the first of the month following the month in which the request is made.
  - **Election Period:** Loss of Employer Group Coverage (Group Retiree, COBRA, and Commercial Coverage)
  - **Election Period Code: SEP – Loss of EGHP Coverage / LEC**

Working past 65 and Coming off Employer or Union Qualified Group Plan. Has Medicare Part A – "DELAYED" enrolling in Medicare Part B:

- Historically, a client would apply for Medicare Part B, correlating the Group termination date with the Medicare Part B effective date (1st of the month). **Today, we are seeing clients coming off group plans ANY day of the month. Since Medicare Part B will always have 1st of month effective date, we suggest having client discuss this with their Group Administrator.**
- **Medicare Supplement:** Client also has the option to take out a Medicare Supplement plan within **63 days.** Must be a Guarantee Issue plan.
- **Plans Available:**
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- Client will need to provide proof of group coverage termination. This includes:
  - ✓ Group carrier name
  - ✓ Policy number
  - ✓ Client and/or Spouse's name
  - ✓ Policy Effective date
  - ✓ SPECIFIC Termination date. * See CCC information below

*__***Certificates of Credible Coverage (ccc)***__ usually have all the information that is needed but are not provided to client until 30 days AFTER the group termination. __***Thus, if client will work with their HR department, the carrier will typically accept a Signed letter on Group letterhead, indicating the above needed information.***__

******We suggest (if any way possible) to place client coming off Employer Group who __already__ has Medicare Part A and B on a __Medicare Supplement plan__. This would be the ONLY WAY a client would have the option for a "Trial Period" under a MAPD plan.***

- *****MA/MAPD/PDP Time Frame, Effective Date and Enrollment Code:**
  - **Time Frame**:
    - **Begins** month group allows for disenrollment **OR** date COBRA ends.
    - **Ends 2** months after group coverage ends
  - **Effective Date:**
    - Can choose an effective date up to 3 months in advance after receipt of election **but not** earlier than the first of the month following the month in which the request is made.
  - **Election Period:** Loss of Employer Group Coverage (Group Retiree, COBRA, and Commercial Coverage)
  - **Election Period Code: SEP – Loss of EGHP Coverage / LEC**

Client is Over 65 and has Medicare Part A and B. Decides to go to work and will Receive Employer Group Health coverage and thus, decides to DROP Medicare Part B: **The client is NOW ready to leave the Group coverage and needs Medicare Part B again (Client must be over 65 and on a group of 20 or more employees)**

- Please call our office to discuss.

Client took out a MA/MAPD plan (using IEP code) when Turning 65 AND enrolling in Medicare Part A and B for the 1st time. NOW…the client wants to **DIS-ENROLL back to Original Medicare** and take out a **Medicare SUPPLEMENT and Stand-Alone PDP plan:**

- At the age of 65 and enrolling in Medicare Part A and B, client took out a MA/MAPD plan. Client **MAY** decide to **not** stay with the MA/MAPD plan and **Dis-enroll** within the 1st year (12 months). Client would then be on Original Medicare and **has the option** to take out a Medicare Supplement and/or a Stand-Alone PDP plan:
  - **Does NOT apply to UNDER 65 age Disability clients**
  - **Only applies to a client who enrolled in MA/MAPD plan when turning 65 AND ALSO getting Medicare Part A and B for the first time**

- **To Accomplish:**
  - **Medicare Supplement:** Client may enroll in Medicare Supplement plan within the 12-month time period.
  - Eligible plans to enroll in:
    - Eligible for Part A **On/or After** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
    - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
  - **Stand-Alone PDP**: Client also needs to take out PDP plan with in the 12-month time period.
    - Election Period: First Time MA Member (Age-In)
    - Election Period Code: **SEP 65**

Client was covered under a Medicare Supplement plan. Client then decided to enroll in a MA/MAPD plan for 1st time.

NOW… **Client wishes to Dis-enroll and go Back to their Medicare Supplement plan within 12 Months:**

- When client drops their Medicare Supplement plan to enroll in a MA/MAPD plan, this is called a **1st Year "Trial Period"**. During this time, the client may go back to Original Medicare and return to the **SAME Medicare Supplement plan and Carrier** they were previously on. Client will also need to enroll in Stand Alone PDP plan.

- **To accomplish this:**
  - **Medicare Supplement:** Client **HAS TO** go back to the **SAME Med Supp Carrier**** and **Plan** they were on before they enrolled in MA/MAPD plan for the 1st time.
    - Medicare Supplement **premiums** must have been **PAID CURRENT.** No gap in coverage going from Medicare Supplement to MA/MAPD plan.
    - 12-month clock starts on MA/MAPD effective date.
    - The Medicare Supplement carrier will want **PROOF** of the MA/MAPD policy termination before re-issuing the prior Medicare Supplement policy. This will be the "official" termination letter client will receive from MA/MAPD carrier and MUST state a **SPECIFIC** termination date. **

  - **Stand Alone PDP**: When written, will cancel the MA/MAPD policy.
    - Election Period: Consumers in an MAPD who drop Medicare Supplement and are in Trial period.
    - Election Period Code: **SEP-Indiv drop Medigap-Trial Period**

**Medicare Advantage TRIAL PERIOD

- If a client has utilized the Medicare Advantage Trial Period (on a Med Supp, then takes out an MA plan for the 1st time and decides they do not want to stay with the plan, they **have the right to go back to the same Plan and Carrier they were on before, guarantee issue within 12 months.**
- **POSSIBLE ISSUE** - IF the Medicare Supplement carrier is no longer available, they have the right to go to another carrier guarantee issue. **BUT… they must follow the NEW January 2020 Guarantee Issue Plan Rules.**
- **For EXAMPLE:** Client went onto Medicare in 2018 and took out a Medicare Supplement Plan G. Client decided to try a Medicare Advantage plan and has now decided they want to go back to their Medicare Supplement Plan G.
  - If their Medicare Supplement carrier is still available – no problem.
  - If their Medicare Supplement carrier is **not still available**, like Transamerica, this client would **not have the option to go back to a "G"** plan guarantee issue, since eligible for Medicare prior to 1-1-2020 and the Guarantee Issue plans before 1-1-2020 are A, B, C, F, K or L.
  - This client would need to take out a plan A, B, C, F, K, or L to be guarantee issue.
  - Of course, they always have the option to go through underwriting to get a different plan. (AARP is best route if medical issues)

General Enrollment Period (GEP) NEW as of 2023

(Late Medicare Part B Enrollment with NO Credible Coverage):

- General Enrollment Period sign up runs from **January 1st through March 31st.**
- A client may enroll during the Medicare General Enrollment period if:
  - **Client does Not have Credible coverage and did not enroll in Medicare Part A* and/or Part B when first eligible**
    - Client may sign up during this General Enrollment Period from January 1st through March 31st each year
    - Coverage will begin **the 1st day of the month following sign up. NEW as of 2023**
      - Sign up in January = February 1st effective date
      - Sign up in February = March 1st effective date
      - Sign up in March = April 1st effective
    - The client may have to pay a **HIGHER** Part A and/or Part B premium due to **Late Enrollment**
- **Medicare Supplement:**
  - Client has 6 months before **and** after Medicare Part B effective date to enroll in plans:
    - Eligible for Part A **On/or After** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
    - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
  - **There are a few** Medicare Supplement carriers who **apply a Pre-Existing clause** if client has not had credible coverage. Please refer to ***Medicare Supplement Cheat Sheets*** document for information.
- **MA/MAPD:**
  - Client **MUST apply BEFORE the Medicare Part B effective date**
  - Client **does Not** have the option to take out MA/MAPD plan after their Medicare Part B has gone into effect.
  - **Enrollment Period Code: ICEP**
    - **Part B goes into effect on February 1 – must apply in January**
    - **Part B goes into effect on March 1 – must apply in February**
    - **Part B goes into effect on April 1 – must apply in March**
- **PDP:** There is NO SEP to enroll in a Prescription drug plan. (Unless client pays for Part A)

RETROATIVE Effective Date - Client's Medicare Eligibility (Part A and B) is Approved with a Retroactive Start Date: (Most common – Under Age 65 Disability clients)

- Client will receive a **"*Notice of Entitlement*"** letter. The **Date of the letter** is the trigger/start date.
- **Medicare Supplement:** Client has 6 months from date on the "*Notice of Entitlement"* letter to enroll in a plan.
- Plans Available:
  - Eligible for Part A **on/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
  - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
- **MA only:**
  - Client has month *"Notice of Entitlement"* is dated & **2** months after Date on the letter to enroll
  - Election Period: Retro Medicare Determination
  - Election Period Code: **Retro Medicare Determination** (MA only)
- **MAPD/PDP:**
  - Client has month *"Notice of Entitlement"* is dated & **3** months after Date on the letter to enroll
  - Election Period: Retro Medicare Determination
  - Election Period Code: **IEP (**MAPD/PDP)

Medicaid DROPS client – Full or Partial (Spend Down):

- Client no longer qualifies for both Medicare and Medicaid, or the state no longer helps pay for their Medicare Premiums.
- **Medicare Supplement:** A Client **CANNOT** go onto a Medicare Supplement in this situation WITHOUT going through Medical Underwriting
- **MA/MAPD/PDP Enrollment** begins, the month client is notified of **Loss of Dual Eligibility** and continues for 2 additional months *(Date on Notification letter and 2 months after)*
  - One Election per calendar year
  - Election Period: Dual-Eligible (Loss of Status)
  - Election Period Code: **SEP-Dual Eligible (Status Loss)**

Client is currently Covered under MA/MAPD/PDP plan. They have a Change of Residence and Move out of Service Area:

- **Medicare Supplement:** Client may enroll in a Medicare Supplement within 63 days of the current MA or MAPD plan's termination.
- Must be a **Guarantee** Issue Plan:
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

- ***Note: Client will need letter they receive from carrier indicating the termination date of the plan to submit with the Med Supp application.***

- ***MA/MAPD/PDP:*** To obtain another plan, enrollment Timeline follows:
  - **BEFORE** the Move: SEP begins the month BEFORE permanent move and ends 2 months after the move.
  - **AFTER** the Move: SEP begins the month client Notifies the Carrier OR the month client was terminated by their current plan due to residing outside of the service area. Ends 2 months after notification of move OR after notification of Plan termination.
  - Election Period: Change of Residence
  - Election Period Code: **SEP-Change of Residence**

Client has a Current Medicare Supplement Policy and has a Change of Residency:

- **Medicare Supplement:** This typically is **NOT** a Guarantee Issue Situation into a new Medicare Supplement plan.
  - Client needs to verify coverage with their Medicare Supplement carrier. **It is VERY rare** for a Medicare Supplement carrier to terminate a policy when a client moves. Typically, the carrier, will continue to cover client at their new residence, adjusting State regulations to policy as needed.
  - Client **DOES** have the option of, Going through medical underwriting or re-writing during Missouri Anniversary timeframe.
- **MAPD:** Is an option to enroll into, IF additional MA/MAPD plans are available at new residence address. SEP is: Change of Residence

MA/MAPD /PDP Plan is no longer offered in area – Non-Renewing:

- Carriers should notify clients covered under *"Non-Renewing"* MA/MAPD/ PDP plans by mid-September. Letter will indicate their plan will not be offered as of January 1st of the following year.
- **Medicare Supplement:** Client has the option of moving to a Guarantee Issue Medicare Supplement plan with effective date options of January 1st through March 1st.

- You would also want to write **Stand-Alone PDP Plan** on client.

***Note:** As indicated, client has option to take **Medicare Supplement** plan for **any available effective date** between January 1st and March 1st. Prescription Drug Plans (PDP) **ALWAYS** have **1st of the month effective dates**. Please keep this in mind as you are helping client.

- Plans Available:
  - Client Eligible for Medicare Part A O**n/or after** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***
- **MA/MAPD/PDP:**
  - Election Period: Non-Renewing
  - Election Period Code: **SEP-Contract Termination**
- Client has from **December 8th through the last day of February of the following year** to enroll in another MA/MAPD/PDP plan. (This is in ADDITION to AEP – October 15th through December 7th).
  - Enrollments made October 15th - December 31st will be effective January 1st.
  - Enrollments made in January will be effective February 1st.
  - Enrollments made in February will be effective March 1st.

- ***Suggestion:*** **Many times, agents will WAIT and schedule client appointments AFTER Annual Enrollment is over (December 7th). You will still have time to meet client's needs with a January 1st effective date.**

Coming off a Medicare Supplement plan that is No Longer sold: Example: Plans "E", "H", "I", or "J":

- **Client options:**
  - During Missouri Anniversary, may enroll in any available Guarantee Issue plan within 30 days front and back of current Medicare Supplement effective date. *
  - If client is out of Missouri Anniversary timeframe, client will need to go through medical underwriting.
- Plans Available:
  - Client Eligible for Medicare Part A **On/or After** January 1, 2020 - ***Plans A, B, D, G, K, L***
  - Client Eligible for Medicare Part A **Prior to** January 1, 2020 - ***Plans A, B, C, F, K, L***

Client is STILL on a "Pre-Standardized" Medicare Supplement Plan:

(Offered before 1980)

- This is a Very Sad Situation for the client.
- The ONLY option to obtain a current Standardized Med Supp plan is to go through medical underwriting.

Section 4 - UNDER AGE 65 DISABILITY

ELIGIBILITY:

➢ After a client receives Disability benefits from Social Security or the Railroad Retirement Board for at least 24 months, your client will automatically receive Medicare Part A and B.

Common Enrollment Scenarios for Underage 65 Disability clients:

Under age 65 Client INITIALLY goes onto Medicare Part A and B (1st time):

- **Medicare Supplement:**
  - To enroll, client has 6 months before AND after their Medicare Part A and **B** effective date.
  - Effective date **may not be** before Part A and Part B effective date.
  - If client **has not had Credible coverage** before becoming eligible, **Pre-Existing** could be a problem. A few carriers have a Pre-Existing clause. Refer to our ***Medicare Supplement Cheat Sheets*** document to verify.
  - Available plans:
    - Eligible for Part A **On/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
    - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
  - Client should also take out a PDP plan (below)
- **Stand-Alone Prescription Drug (PDP):**
  - To enroll, client has 3 months before, Month of and 3 months after, Medicare **Part A and B** effective date.
  - Effective date may not be before Medicare Part **A** and B effective date
  - Election Period: Newly Eligible
  - Election Period Code: **IEP**
- **Medicare Advantage (MA/MAPD)**
  - To enroll, client has 3 months before, Month of and 3 months after, Medicare **Part A and B** effective date.
  - Effective date may not be before Medicare Part A and **B** effective date
  - Election Period: Newly Eligible
  - **MA** Election Period Code: **ICEP**
  - **MAPD** Election Period Code: **IEP**

***Underage 65 client enrolls in Medicare Advantage (MA/MAPD) plan when 1st eligible for Medicare Part A and B:

- If underage 65 client takes out a MA/MAPD plan when 1st eligible, **they DO NOT have the option within the 1st year, to come off their MAPD plan (back to Original Medicare) and take out a Guarantee Issue Medicare Supplement plan.**
- This option is ONLY available for clients **Turning 65 AND getting Medicare Part A and B for the first time.**
- ***Suggestion, I realize, premium cost is often a major factor during this time in a client's life. But, if there is an option, we always suggest the client enroll in a Medicare Supplement plan when 1st eligible for Medicare. This allows client to be eligible to enroll in a Medicare Advantage plan sometime down the road and have the 1st time Trial Right period to go back to same Medicare Supplement they were on, within the 1st year.***

Under age 65 and is eligible for Medicare Parts A and B. Client has DELAYED Medicare Part B and STAYED on an EMPLOYER GROUP HEALTH PLAN (100 or more Employees)

Note: Age 65+ have different Group Employee numbers

- ***POSSIBLE CLAIM ISSUE***
- Under age 65 (has Medicare Part A and has **Delayed** Part B) and is covered under Employer Group health plan based on, a Spouse, a Family member, or their own employment:
- **WHO PAYS FIRST:**
  - **Employers with 100 or MORE employees:**
    - Employer Group pays 1st. Group will pay up to the limits of its coverage.
    - Medicare pays 2nd. Medicare may not pay all the uncovered costs.
  - **Employers with LESS than 100 employees ***ISSUE*****
    - **Medicare pays 1st**. Thus, since client does not have Medicare Part B, **No Medicare Part B expenses will be paid**.
    - Employer Group pays 2nd. We have seen multiple situations where; Group states client needs to be enrolled in Medicare Part B, for them to be secondary payor of any expenses incurred under Medicare Part B.
- ***It is important to strongly urge you clients to work with their Group HR department and have them clarify benefit coverages.***

Under age 65 client is Turning 65. Client is already enrolled in Medicare Part A and B:

- Client receives a **NEW WINDOW** for Enrollment options:
- **Medicare Supplement**:
  - Client may apply or switch plans within 6 months Front and Back of clients **65th Birthday month.**
  - **Plans Offered:**
    - Eligible for Part A **On/or after** January 1, 2020: **Plans A, B, D, G, HDG, K, L, M, N**
    - Eligible for Part A **Prior to** January 1, 2020: **Plans A,B, C, D, F, HDF, G, HDG,K,L,M,N**
- **Prescription Drug Plan (PDP)**:**
  - Client may apply or switch plans, 3 months before, month of or 3 months after clients **65th birthday month**. Effective date cannot before 65th birthday month.
  - Election Period: Age-In (Eligible Prior to Age 65)
  - Election Period Code: **IEP2**
- ***PDP PERK** -- If client has incurred a PDP Late Enrollment Penalty before turning 65, the penalty is wiped clean upon turning 65.*

- **Medicare Advantage Prescription Drug Plan (MAPD):**
  - Client may apply or switch, 3 months before, month of or 3 months after clients **65th birthday month**. Effective date cannot be before clients 65th birthday month.
  - Election Period: Age-In (Eligible Prior to Age 65)
  - Election Period: **IEP2 (MA-PD)**
  - No election for MA-only plan

Section 5 - Medicaid

MEDICAID and MEDICARE - Definitions

- **Medicaid** is a joint Federal and State program that helps pay medical costs for certain individuals and families with limited incomes, resources, and who meet state specific guidelines. Medicaid may also cover services not normally covered by Medicare (such as long-term support and services and personal care services). Each state has different guidelines about eligibility and applying for Medicaid. If a person qualifies for Medicaid in their state, they automatically qualify for "***Extra Help"***. This will help pay for Medicare prescription drug coverage (Part D).

- Medicaid in Missouri is called ***Missouri Healthnet.***

- **MEDICARE** is the **PRIMARY** payer for most services**, BUT** **Medicaid** **covers Benefits NOT offered by Medicare.**

- **Medicare** eligible **Dual beneficiaries** or **"Duals":** Individuals who qualify for both Medicare **AND** Medicaid.

- **Special Needs Plan – (SNP):** Product designed for clients with specific chronic health conditions **and/or** who are eligible for full Medicaid benefits. The **plans offer benefits in addition** to those covered under Original Medicare such as routine dental, vision, hearing, transportation, and routine podiatry services. ******Clients who qualify for these plans have additional enrollment options***

- **Beneficiaries with Limited Income and Resources (LIS)**
  Clients with limited income and resources, should be encouraged to apply for Low-Income Subsidy (LIS), also known as "***Extra Help"*** through their state's Medicaid or Social Security Administration office (SSA). Once, the agency approves the application for "***Extra Help"***, it will become effective the 1st day of the month in which the individual applied.

- **Spend Down Definition:**
  The amount of money **PER MONTH** client must pay **"Out-of-Pocket"** before Medicaid takes over.

- **Missouri EFT Draft of Spend Down Money:**
  Missouri sends a letter to Medicaid clients who have a ***Spend Down***. This letter can be confusing to some. Medicaid asks client to sign up for EFT monthly payments through their bank. MANY clients think this is a **"Insurance Premium**" they **MUST** pay to Medicaid to receive services. **THIS IS NOT A PREMIUM!** It is their personal "*Spend Down"* amount.

Categories of Dual Eligible Beneficiaries and Out-of-Pocket costs Paid by Medicaid

- **QMB (only): Qualified Medicare Beneficiary**
  - Medicare Part A (if any) and Part B premiums
  - Cost sharing for Part A and Part B benefits

- **QMB Plus: Qualified Medicare Beneficiary Plus +**
  - Medicare Part A (if any) and Part B premiums
  - Cost sharing for Part A and Part B benefits
  - Full Medicaid Benefits

- **SLMB (only): Specified Low-Income Medicare Beneficiary**
  - Medicare Part B premiums

- **SLMB Plus: Specified Low-Income Medicare Plus + Beneficiary**
  - Medicare Part B premiums
  - Full Medicaid Benefits

- **QI: Qualifying Individual**
  - Medicare Part B premiums

- **FBDE: Full Benefit Dual Eligible**
  - Medicare Part A (if any) and Part B premiums
  - Full Medicaid Benefits

- **(QDWI): Qualified Disabled Working Individual**
  - Part A Premium

Special Medicaid Election Periods (SEP)

Missouri Rx: Pharmacy Assistance Program Provided by the State:

- Client belongs to a pharmacy assistance program provided by their state. As of June 30, 2017, **Missouri Rx only accepts** **FULL DUAL** Medicaid and Medicare clients.
- **MAPD/PDP**:
  - One election per Calendar year
  - Effective date will be the 1st of the month following Receipt and Approval from the State
  - Client **MUST** have **current Prescription Drug plan in force**
  - Election Period: SPAP Members
  - Election Period Code: SEP-SPAP Enrollee (MAPD/PDP)
  - Missouri Rx is **NOT** considered Credible Coverage

Client is on Medicare and Medicaid: (FULL or PARTIAL Spend Down):

- Client has both Medicare and Medicaid **OR** the state helps pay for their Medicare Premiums.
- **MA/MAPD/PDP** - Client may take out and/or change plans **ONCE during each of the FIRST 3 QUARTERS of the calendar year.**
  - Election Period: Dual-Eligible (Full Benefit and Partial)
  - Election Period Code: **SEP-Dual Eligible Full and Partial**
  - ***Example:***

Mrs. Hurlbut has both Medicare and Medicaid and is covered on a MAPD plan with Company X. She has the option to change plans 1 time during:

- ✓ January, February, and March (February, March, and April Effective dates)
- ✓ April, May, and June (May, June, and July Effective dates)
- ✓ July, August, and September (August, September, and October Effective dates)

- **Medicare Supplement:** This does **NOT** activate a Guarantee Issue Enrollment Period.

Medicaid Drops Client with Full or Partial Spend Down:

- Client no longer qualifies for both Medicare and Medicaid OR the state no longer helps pay for their Medicare Premiums.
- **MA/MAPD/PDP:**
  - **Enrollment** must be within **3** months of loss of Dual/LIS level OR notification of such a change, whichever is later.
- **Effective date** will be the 1st day of the month following receipt of election.
- **One** Election per calendar year
  - Election Period: Dual-Eligible (Loss of Status)
  - Election Period Code: **SEP-Dual Eligible (Status Loss)**
- **Medicare Supplement:** A Client **CANNOT** go onto a Medicare Supplement in this situation **WITHOUT** going through Medical Underwriting.

Low-Income Subsidy (Extra Help/LIS) – (NON-MEDICAID):

- Eligible beneficiaries who have a limited income may qualify for a Government program that helps pay for Medicare Part D Prescription Drug coverage. Medicare beneficiaries **(not on Medicaid**) who are receiving **Low-Income Subsidy (LIS),** will receive assistance paying for their Part D monthly premium, annual deductible, Co-insurance, and Co-payments.
- **MAPD/PDP:**
  - Effective date will be 1st of the month following Receipt of Election (Date on letter)
  - Client may take out and/or change plans ***ONCE during each of the first 3 quarters of the calendar year***
  - Election Period: LIS (Non-Medicaid & Maintaining LIS)
  - Election Period Code: **SEP-LIS (Non-Medicaid/Maintaining LIS)**

Client NO longer qualifies for "Extra Help" to pay for Medicare Prescription drugs:

- **MAPD/PDP**
  - Client has a One-time SEP to Dis-enroll from OR switch their MAPD/PDP plan
    - Begins when client is notified of the Loss and ends 2 months after notification (Month of and 2 months after)
    - Election Period: LIS (Loss of Status)
    - Election Period Code: **LIS (Loss of Status)**

CMS AUTO-ENROLLMENT of Medicare Advantage or Prescription Drug Plan

- Clients who automatically qualify for Extra Help will receive a letter stating, **"You're being enrolled in a Medicare Drug Plan"**
  - **YELLOW or GREEN letter** – means they qualify for Medicare and Medicaid AND currently get benefits through Original Medicare.
  - **PURPLE letter** – means they qualify because of any of the following: Client has both Medicare and Medicaid, Client is in Medicare Savings Program, or client receives Supplemental Security Income (SSI) benefits.
- **The plan chosen for a client, must ALWAYS have a monthly premium LESS than the LIS Subsidy amount and is completely random.**
  - Letter should indicate:
    - Client is being enrolled in a Rx plan with a certain Carrier / Plan and Effective Date
    - Premium amount, Deductible amount, and LIS Co-Pay level
    - Company phone number to discuss questions or needs
    - It will list out other carrier's Extra Help plans client has option to enroll in.
- **MA plan:** If the client enrolls in a PFFS plan **WITHOUT** drug coverage, Medicaid will automatically enroll the client in a PDP plan.
- **MAPD plan:** If the client enrolls in a MAPD plan, this satisfies the Medicaid Rx requirements.
- Available Medicare Drug Plans **differ per STATE.** Call anytime for details or a copy of sample client letters.
- Client has the right to take out Prescription Drug plan coverage of their own election. **They do not have to stay on the plan they are automatically enrolled** in through Medicaid.
- **You as agent, can enroll a client in this situation.**

2023 – Extra Help Medicare Drug Plans in Missouri

WellCare	WellCare Classic (PDP)
Aetna Medicare	SilverScript Choice (PDP)
Cigna	Cigna Secure Rx (PDP)
Humana	Humana Basic Rx Plan (PDP)
Clear Spring Health	Clear Spring Health Value Rx (PDP)

- **Suggested reading for you and your clients from CMS Publications:**
  - ***"What you should do if you no longer Qualify for Extra Help with Medicare Prescription Drug Costs"***
  - ***"If you get Extra Help, Make Sure you're Paying the Right Amount"***
  - ***"4 Programs that can Help You Pay your Medical Expenses"***
  - ***"What is Medicare – What is Medicaid"***

Section 6 - GOVERNMENT CREDIBLE HEALTH PROGRAMS

GOVERNMENT CREDIBLE HEATH PROGRAMS

Federal Employees Health Benefits Program (FEHB):

- The Federal Employees Health Benefits Program (FEHB) provides coverage for current and retired Federal employees and their covered family members.
- The Federal Employees Health Benefits Program (FEHB) plans usually include Prescription Drug coverage. However, if a client desires to join a Medicare Drug plan (PDP), their FEHB health benefits coordinator will advise "Who Pays First". (Typically, Medicare PDP plan will pay 1st, but always advise client to verify)
- **Suggested reading for you and your clients from the U.S. Office of Personnel Management:**
  - *Federal Employees Health Benefits (FEHB) Facts -*

Indian Health Services (IHS):

- The Indian Health Services (IHS) provides health care for American Indians and Alaskan Natives. Many Indian health facilities participate in the Medicare Prescription Drug (PDP) program. If client obtains prescription drugs through an Indian Health facility, they will continue to obtain the drugs at no cost to them and coverage will not be interrupted.
- Joining a Medicare drug plan may help the Indian Health facility because the drug plan pays the Indian Health facility for the cost of client's prescriptions. It is best for client to talk to their local Indian Health benefits coordinator to help choose a plan that meets their needs and explain how Medicare works with their Indian Health Care system.
- **Suggested reading for you and your clients from CMS Publications:**
  - *The Value of Health Insurance for the American Indian or Alaska Native*
  - *Tribal Glossary Brochure*
  - *Medicare Prescription Drug Plans for American Indians and Alaska Natives*

TRICARE: (Military Health Benefits):

- The TRICARE program provides health care plans for Active-Duty service members, Military Retirees, and their families.
- **Medicare Part B and TRICARE:**
  - **Client must have Medicare Part A and B to keep their Tricare coverage**.
  - **However**, if they are an Active-Duty service member, the spouse or dependent child of an Active-Duty service member:
  - Client does NOT have to enroll in Medicare Part B to keep TRICARE coverage while their status remains Active-Duty.
  - Before an Active-Duty service member retires, **they must enroll in Medicare Part B** to keep their TRICARE coverage without a break in coverage.
  - If client is 65 or older or disabled, the client may get Medicare Part B during a Special Enrollment Period (SEP).

- Losing TRICARE and Joining a MAPD/PDP plan – PDP Penalty:
  - If client loses TRICARE coverage, (which includes Prescription drug coverage), the client will NOT pay a Medicare Part D Late Enrollment penalty if they enroll in a Medicare Advantage or Prescription Drug plan within 63 days of the loss.
- **Who Pays First:**
  - Tricare **NEVER** pays first for covered services that are covered by Medicare. They only pay after Medicare, Employer Group Health plan, and/or Medicare Supplement Insurance plan has paid.
- **Medicare Prescription Drug (PDP) plan:**
  - If client has Tricare, they do not have to join a Medicare PDP plan. However, if they do join, the Medicare PDP plan pays **First,** and Tricare will pay Second.
- **Medicare Advantage MAPD plan (HMO or PPO)**
  - If client joins a Medicare Advantage plan (HMO or PPO), with prescription drug coverage, their Medicare Advantage plan (MAPD) and TRICARE may coordinate their drug benefits. **AS LONG AS clients MAPD network pharmacy** is **also a TRICARE network pharmacy**. Otherwise, the client would need to file their own claims to be reimbursed their Out-of-Pocket expenses.
- **Receiving services from a Military hospital:**
  - If client receives services from a Military hospital, or any other Federal Health Care Provider, **TRICARE will pay their bills.** Medicare usually does not pay for services a client would receive from a Federal Health Care Provider, or any other Federal Agency.
- **TRICARE Plans:**
  - TRICARE Prime
  - TRICARE Select
  - TRICARE for Life

- **Suggested reading for you and your clients may be found at: tricare.mil/publications**

- ***Note: If you are interested in receiving more information on Tricare or wish to sell Tricare Medicare Supplement policies, please call our office.***

Veteran Affairs Benefits (VA):

- The *Veteran Affairs* (VA) provide health coverage for Veterans of the U.S. military. Client may also receive prescription drug coverage through the U.S. Department of Veteran Affairs (VA) program. If client decides to join a Medicare Prescription Drug (PDP) plan, they CANNOT use both types of coverage for the same prescription.
- **Who Pays First:**
  - If client has, or can receive BOTH Medicare and Veteran Affairs benefits, they may use **either** program for Provider health care services
  - When client obtains health care, they **must choose** which benefit to use each time they see a doctor or receive services.
  - Medicare usually does not pay for services a client receives from a Federal VA facility.
  - Medicare will **NOT** pay for the same service that was covered by Veteran Affairs (VA) nor will Veterans Affairs (VA) pay for services that were covered by Medicare.
  - **ALSO,** Medicare will never be a secondary payor after the Department of Veteran Affairs

- ***NOTE:* To receive Veteran Affairs benefits to pay for services, the client must go to a VA facility or have the Veteran Affairs authorization to receive services in a Non-VA facility.**

- **<u>Special "Rare" Situation Where Medicare and Veteran Affairs (VA) may BOTH pay:</u>**
  - The Veteran Affairs (VA) authorizes services in a **<u>NON-Veteran Affairs</u>** (VA) facility, **<u>but did</u>** **<u>not</u>** authorize **<u>ALL,</u>** the services the client received during their hospital stay. At this point, Medicare "may" pay for the Medicare approved services the Veteran Affairs (VA) did not authorize.
- **Example:**
  - Bob, a Veteran, goes to a NON-Veteran Affairs (VA) facility for services **<u>authorized</u>** by the VA. While at the Non-VA facility, Bob receives other Non-VA authorized services the Veteran Affairs (VA) will NOT pay for.
- Medicare may pay for some of the Non-VA authorized services that Bob received. Bob would be responsible for services that **neither** Medicare nor the Veteran Affairs (VA) do not cover.

- **Suggested reading for you and your clients may be found at: va.gov/vapubs/**

Section 7 - HELPFUL PHONE NUMBERS FOR YOU and YOUR CLIENTS

Insurance Specialties (Our Office) **www.insspecial.com** **800-789-0182**

MEDICARE: www.medicare.gov **800-MEDICARE** **800-633-4227**
General or Claims-specific Medicare Information

SOCIAL SECURITY ADMINISTRATION www.socialsecurity.gov **800-772-1213**
Get a replacement Medicare card, change address or name, find out if a client is eligible for Part A and/or Part B and how to enroll, apply for Low-Income Subsidy (LIS) Extra Help with Medicare prescription drug, ask questions about premiums, and report a death

MEDICARE GROUP BENEFITS
COORDINATION & RECOVERY CENTER (BCRC) **855-798-2627**
The Benefits Coordination and Recovery Center is a 3rd party organization that helps Medicare know what carrier is primary on each beneficiary.

END-STAGE RENEAL DISEASE (ESRD) **800-772-1213**
If client has End-Stage Renal Disease (ESRD), they will need to call or visit their Social Security Administration office for more information on what is available to them.

MEDICAID / DEPARTMENT OF SOCIAL SERVICES
State of Missouri **www.medicaid.gov** **800-392-2161**
All other states **(ask for Medicaid & state)** **800-663-4227**
State funded program for individuals and families in need. Help for medical care.

DEPARTMENT OF VETERAN AFFAIRS (VA) www.va.gov **800-827-1000**
For veterans and their families

TRICARE / DEPT OF DEFENSE HEALTH **www.tricare.mil** **866-773-0404**
LIFE and PHARMACY **877-363-1303**
Health care plan for Active-Duty Service Members, Military Retirees, and their families

RAILROAD RETIREMENT BOARD (RRB) www.rrb.gov **877-772-5772**
If client has benefits from the RRB, they can use this number to change their address or name, check eligibility, enroll in Medicare, replace ID card or report a death

FEDERAL EMPLOYEE HEALTH BENEFITS (FEMB) **888-767-6738**
Health coverage for current and retired Federal employees and their family members

INDIAN HEALTH SERVICES (IHS) **www.ihs.gov** **800-225-0241**
Health care services for American Indians and Alaskan Natives

Section 8 - HELPFUL RESOURCES FOR YOU and YOUR CLIENTS

Documents created by *Insurance Specialties*:

- Medicare Supplement Cheat Sheets: *Provides you with a detailed comparison of Medicare Supplement carriers. Side by side information helps you find,* ***What carrier would best cover your client's needs****, determine* ***Premium Rate****, If* ***Household Discounts*** *apply,* ***Tobacco*** *or* ***Non-Tobacco*** *and many more needed tips.*

- Medicare Supplement Commission Strategies: *How and* ***"if"*** *you will be* ***paid*** *in different enrollment scenarios. You will also find whether you need to be* ***Pre-Appointed*** *with a carrier to write new business and* ***what Agent number*** *to use on an application.*

- Medicare Advantage (MAPD), Prescription Drugs (PDP) and Medicare Supplement - Day to Day Operations Guide: *How to* ***submit business****,* ***E-App*** *Step by Step, look up* ***network providers****, Order* ***Supplies****, Carrier* ***contact information****, obtain* ***Commission statements*** *and more.*

- Medicare Advantage (MAPD) and Prescription Drugs (PDP) Grid: *Overall view of current* ***MAPD/PDP*** *plans and coverages.*

- Ancillary Product Comparisons: *Comparisons and brochures of Carrier plans we feel who are offering products* ***best fitting clients current needs****. Hospital Indemnity, Home Health Care, Dental, Vision, Short term, Cancer, and more.*

- Shelli's News: *Periodic e-mail -* ***Updates*** *on Health Market, Carrier and Plan changes, Mergers and Acquisitions, New products, who is paying you commissions and more!*

Resources

MEDICARE & YOU:

Medicare & You is the official U.S. Government Medicare Handbook: Your client will receive automatically when initially eligible for Medicare and each year thereafter, in the fall. You may order this helpful tool to have on your desk, or refer to it by going to: www.medicare.gov

Medicare.gov website:

The Medicare.gov website is a **great resource** for a variety of information. It is very helpful for your clients and for your own general knowledge. I like the free ***PUBLICATIONS*** section. Once you log into Medicare.gov, Click the blue box at the Top/Right side of the page – ***Forms, Help and Resources***. Once there, scroll down to **Publications.** Then to Search. Here are a few examples of what you can find:

- **Medicare & You**
- **Who Pays First**
- **Diabetes**
- **Durable Medical Equipment**
- **Who Covers a Shingle Vaccine?**
- **Turning 65**
- **When Should I enroll into Medicare Part B**
- **Claims and much more**

Most publications are available in multiple languages. You can download, print, and some can be mailed to you. I suggest having supplies on hand for Newly eligible clients – Turning 65 or coming off group.

Quick E-mail Tip and Supplies: **I believe it is very important to provide information to your clients direct from Medicare/CMS when needed.**

When you have pulled up information you are looking for, go to the address box at the top of the page, right click and copy. Then Paste the link into an e-mail. You can save for future reference OR send the information to your client. **Thus, sending them information directly from Medicare versus you just telling them the information**.

Choosing a Medigap Plan publication

This publication is to go to each client when you are presenting or selling a Medicare Supplement application. Each carrier should provide you with copies or we can order them for you. *FYI*…typically this publishes late spring of the year it covers.

www.socialsecurity.gov

Get a replacement Medicare ID card, change address, or name, find out if the client is eligible for Part A & / or Part B & how to enroll, apply for Low-Income Subsidy (LIS) or Extra Help with Medicare prescription drug costs, ask questions about premiums, & report a death.

www.medicaid.gov

State funded program for individuals & families in need of help to pay for medical care. You will find; How to apply, different levels of Medicaid, Spend Down information, and much more.

- www.cms.gov

Resources for Senior and Underage. Learning & Training.

- www.mymedicare.gov

This is Medicare's free, secure, online service for managing personal information regarding Original Medicare benefits and services. Beneficiaries can create an account and use it to check information about their coverage, enrollment status and Medicare claims.

Encyclopedia - Good information on Drugs

https://medlineplus.gov/encyclopedia.html

- Details on Foreign Travel

https://www.medicare.gov/supplement-other-insurance/medigap-and-travel/medigap-and-travel.html

- MACRA Reference Guide

- Who Pays First – Brief Overview

https://www.medicare.gov/supplement-other-insurance/how-medicare-works-with-other-insurance/who-pays-first/which-insurance-pays.html

- Prescription Drugs Coming off Patent Timeline

- Medicaid Spend Down & LIS - You can pull up each state

https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html

REFERENCES

www.medicare.gov

www.cms.gov

www.socialsecurity.gov

www.medicaid.gov

www.va.gov

www.ihs.gov

www.medicaremissouri.com

Medicare & You (The official U.S. government Medicare handbook)

National Council on Aging (NCOA)

Medicare Basics: (A guide for families & friends of people with Medicare)

Enrolling in Medicare Part A & Part B

Your Medicare Benefits: (CMS Publication)

Your Guide to Medicare's Preventive Services

Medicare Prescription Drug Benefit Manual: Chapter 4 Creditable Coverage Period Determination & the Late Enrollment Penalty

Your Guide to Medicare Prescription Drug Coverage

Medicare Made Clear by United Healthcare (UHC)

Disability Benefits: (Social Security Publication)

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (CMS & NAIC)

Medicare & Home Health Care (CMS Publication)

Medicare Premiums: Rules for Higher-Income Beneficiaries (Social Security Publication)

www.ahipmedicaretraining.com

Social Security: Medicare Premiums – Rules for Higher-Income Beneficiaries

Welcome to Medicare (CMS Publication)