SilverScript Product and Process Course

Updated August 6, 2017

2018 Annual Certification

Welcome to SilverScript University

- At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans
- CMS requires that marketing agents and brokers be tested annually on rules, regulations, and details about the products they sell
- To help you properly represent our products, we have developed a training & certification program
  - The program consists of several easy-to-follow online training courses
  - Each module presents information on a different subject, testing your knowledge along the way with questions on what you have learned
  - Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next course

Welcome to SilverScript University

- As you move forward, please take your time and pay close attention to the information presented in the training courses. If you have any questions, please contact your supervisor
- We have placed copies of the training courses on the SilverScript Enrollment Portal under the Reference Materials link
- Feel free to print the training materials and reference them as you take the certification test
- You must pass each course within three attempts
- We want you to be well informed as you represent SilverScript
- In addition to the training requirements, in order to sell Medicare products a licensed agent or broker must be appointed in accordance with the appropriate State's appointment law for each state the agent or broker is licensed

Welcome to SilverScript University

At the completion of this training module, you should have an understanding of the following:

- SilverScript Insurance Company – the organization & our key differentiators
- SilverScript PDP benefit designs for 2018
- What you must do before you can sell for SilverScript
- The enrollment process for SilverScript PDPs
- Enrollment and Disenrollment guidance
- Additional SilverScript-specific compliance information

SilverScript Insurance Company

- SilverScript stand-alone prescription drug plans (PDPs) are sponsored by SilverScript Insurance Company, a CVS Health company
- SilverScript contracts with Medicare to provide simple and complete prescription drug coverage to members in all 50 states and the District of Columbia
- Our History:
  - SilverScript has acquired other Part D plans and two insurance companies over the past several years:
    - Part D members from:
      - Rx America
      - Community CCRx
      - Health Net
      - Medi CareFirst
      - United American Insurance Company
      - First United Life Insurance Company
    - Insurance Companies:
      - Pennsylvania Life Insurance Co
      - Accendo Insurance Company

Who We Are

- CVS Health is reinventing pharmacy to have a more active, supportive role in health care. We're a pharmacy innovation company and every day we're working to make health care better
  - CVS Pharmacy has more than 9,600 retail drug stores in 49 states, the District of Columbia, and Puerto Rico
  - CVS caremark - The pharmacy benefit management (PBM) and mail service division of CVS Health provides a full range of PBM services for more than 75 million plan members
  - CVS minute clinic - The retail medical clinic division of CVS Health is the leading retail medical clinic provider in the United States
  - CVS specialty - The specialty pharmacy division of CVS Health provides an array of specialty pharmacy services for patients who require treatment for rare or complex conditions
- CVS Health is #7 on the 2017 Fortune 500 with over $177 billion in revenue

SilverScript Specializes in Medicare Part D

- Unlike other Medicare insurers, Part D is the only coverage SilverScript offers
- Our name may not be familiar to people until they become eligible for Medicare since we only offer Part D coverage
- As people learn more about SilverScript plans, they will understand why millions of people with Medicare choose SilverScript to protect their savings against the cost of prescriptions
- Now in our second decade of supporting Medicare
  - The Medicare Part D program began in 2006
  - At that time, Medicare selected a group of insurers to help eligible Americans access and pay for their prescription drugs
  - As part of that select group, SilverScript is proud of its work within the Medicare program to help improve the health of America's seniors and people with disabilities
  - Since Medicare Part D began, SilverScript has had one focus: to deliver Medicare prescription drug coverage that works well every day, in every way

SilverScript Brand Promise

For Medicare Part D beneficiaries, we offer **confidence** over confusion and **comfort** that comes with **consistency**. With SilverScript, every prescription is more than a mere transaction; each is a **commitment** to demonstrate our **expertise** and sole focus on **delivering** Part D coverage that helps keep participants on their path to better health.

We've been here since Medicare Part D began in 2006, and we focus 100 percent on delivering prescription drug coverage that works well in every way, every day. We go the extra mile to educate, explain and **empathize** and provide Part D beneficiaries with trust and **peace of mind** that they have chosen the right plan that **cares** for them.

SilverScript Choice is Nation's Largest Basic PDP

- According to the CMS Monthly Enrollment by Plan report, the SilverScript Choice PDP was the largest Basic Enrollment PDP

Rank	Parent Organization	Market Share	2017 Total Enrollment	Basic Enrollment	Enhanced Enrollment	Group Enrollment
1	**CVS Health**	**22.0%**	**5,518,896**	**4,308,032**	**192,019**	**1,018,845**
2	UnitedHealth Group	21.4%	5,354,464	1,516,593	3,234,926	602,945
3	Humana	20.4%	5,121,082	1,883,348	3,228,036	9,698
4	Express Scripts	11.0%	2,763,594	500,072	55,683	2,207,839
5	Aetna	8.3%	2,073,682	1,166,235	789,144	118,303
6	WellCare	4.5%	1,130,772	1,045,074	85,698	0
7	CIGNA	3.3%	821,713	560,772	204,167	56,774
8	Rite Aid	1.4%	360,916	329,708	0	31,208
9	Health Care Service Corp	1.4%	357,942	120,600	228,208	9,134
10	Anthem	1.1%	287,586	95,546	167,233	24,807
	Next 15	4.5%	1,138,178	583,153	198,813	356,212
	Top 25 Total	99.5%	24,928,825	12,109,133	8,383,927	4,435,765

Source: CMS July 1, 2017, payment file (reflects enrollments accepted through June 9, 2017)

2018 SilverScript Choice (PDP)

- SilverScript Choice – a plan with lots of zeros - $0 deductible on ALL tiers, $0 copay on Tier 1 drugs through CVS Caremark Mail Service Pharmacy, and lower monthly premiums.
  - **DEDUCTIBLE**: $0 deductible in all states except Alaska, Arizona, and Hawaii.
    - $0 deductible applies to ALL 5 tiers.
    - In Arizona and Hawaii, $0 deductible applies to Tier 1 and Tier 2. There is a $100 deductible for Tiers 3 through 5.
    - In Alaska, there is a $405 deductible that applies to all tiers.
  - **PREMIUMS**: Low monthly premium
    - The premium is lower in 2018 than in 2017 in all states except in Arkansas and Hawaii (but don't worry, the premium in Arkansas is still under $17 and in Hawaii it is still under $24).
    - The Choice PDP premium is below the benchmark in 32 out of 34 regions (in other words, it is below the benchmark in every state except Alaska and Nevada).
  - **NEW PHARMACY NETWORK**: The Choice Network includes more than 67,000 pharmacies and the CVS Caremark preferred mail service pharmacy.
    - NEW for 2018: The Choice Network includes over 26,000 Preferred retail pharmacies and over 41,000 Standard retail pharmacies.
    - Tier 1 - Preferred Generic drugs have a $0 copay through our mail service pharmacy.
  - **FORMULARY**: While the formulary still includes over 3,300 drugs, some drugs were replaced with different drugs.
    - Great news: SilverScript has moved dozens of drugs to a lower tier than the tier it was on in 2017. You will be able to find a "downtiered" drug list on the SilverScript Agent Portal closer to the start of the AEP.
    - We will be offering some drugs in 2018 where members can receive a 90-day supply for almost the same or lower copay than the 2017 30-day supply for a similar medication. Details will be announced around October 1st.

2018 SilverScript Choice PDP Designs

SilverScript Choice								
Regions	Most Regions		AZ		HI		AK	
Annual Deductible	$0 applies to all tiers		$0 T1 & T2, $100 T3-T5		$0 T1 & T2, $100 T3-T5		$405 applies to all tiers	
Initial Coverage (ICL)	**Retail Pref/Std**	**Mail Preferred**	**Retail Pref/Std**	**Mail Preferred**	**Retail Pref/Std**	**Mail Preferred**	**Retail Standard**	**Mail Preferred**
	30-day	90-day	30-day	90-day	30-day	90-day	30-day	90-day
Tier 1	$3-$9 / $6-$10	$0	$3 / $7	$0	$3 / $7	$0	$1	$0
Tier 2	$10-$19 / $19-$20	$25-$47.50	$16 / $20	$40	$13 / $20	$32.50	$4	$10
Tier 3	$34-$46 / $44-$47	$85-$115	$41 / $47	$102.50	$41 / $47	$102.50	17%	17%
Tier 4	34%-49% / 44%-50%	34%-49%	45% / 50%	45%	45% / 50%	45%	36%	36%
Tier 5	33%	N/A	31%	N/A	31%	N/A	25%	N/A
Coverage Gap (donut hole)	Members leave the ICL stage and enter the Medicare Coverage Gap when they have reached $3,750 in total yearly drug costs (not including monthly premiums) Generic drugs: Members pay 44% of the cost Brand drugs: Members pay 35% of the cost							
Catastrophic Coverage (after donut hole)	Members enter the Catastrophic Coverage stage when they have spent $5,000 out of pocket (not including monthly premiums) Generic drugs: Members pay the greater of 5% coinsurance or $3.35 copay All other drugs: Members pay the greater of 5% coinsurance or $8.35 copay							

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017
Premiums and coinsurance vary by region to comply with CMS equivalence rules.

"Less Than" Logic

- Did you know that sometimes a medication may cost less than the drug tier copay?
- We want to make sure you know that a member will pay whichever is lower: SilverScript's negotiated drug price or the tier copay. For example, if the SilverScript negotiated drug price is $1.34 and the tier copay is $3, the member will be automatically charged the $1.34 and not the $3 tier copay.
- Prices changed frequently.
- We did an analysis of the 2018 SilverScript Choice formulary. On average, the cost for approximately 100 drugs were lower than the Tier 1 and Tier 2 copays. Here are the results from a June 2017 analysis:

States	Approx. Drug Count	States	Approx. Drug Count	States	Approx. Drug Count	States	Approx. Drug Count
Alabama	101	Illinois	81	Montana	102	Rhode Island	110
Alaska	139	Indiana	95	Nebraska	102	South Carolina	70
Arizona	74	Iowa	102	Nevada	53	South Dakota	102
Arkansas	106	Kansas	100	New Hampshire	77	Tennessee	101
California	82	Kentucky	95	New Jersey	92	Texas	73
Colorado	64	Louisiana	113	New Mexico	82	Utah	89
Connecticut	110	Maine	77	New York	109	Vermont	110
Delaware	74	Maryland	74	North Carolina	98	Virginia	82
DC	74	Massachusetts	110	North Dakota	102	Washington	113
Florida	59	Michigan	92	Ohio	85	West Virginia	108
Georgia	99	Minnesota	102	Oklahoma	114	Wisconsin	116
Hawaii	166	Mississippi	95	Oregon	113	Wyoming	102
Idaho	89	Missouri	118	Pennsylvania	108		

Note: Actual drug costs change frequently and vary by pharmacy
Source: SilverScript Insurance Company Actuarial Services, as of June 19, 2017

SilverScript Choice Premiums - By State

States	Region	SilverScript Choice 2018	SilverScript Choice 2017	SilverScript Plus 2018	SilverScript Plus 2017
Alabama	12	$25.40	$28.90	$46.20	$68.90
Alaska	34	$53.30	$54.40	Not Available	Not Available
Arizona	28	$28.50	$29.70	$74.00	$75.90
Arkansas	19	$16.40	$15.70	$47.80	$51.60
California	32	$28.50	$29.90	$79.70	$83.70
Colorado	27	$29.90	$32.00	$75.70	$79.90
Connecticut	2	$29.40	$32.30	$63.80	$67.90
Delaware	5	$29.50	$33.90	$77.60	$81.90
District of Columbia	5	$29.50	$33.90	$77.60	$81.90
Florida	11	$26.40	$28.90	$71.40	$75.00
Georgia	10	$19.60	$22.80	$46.20	$55.10
Hawaii	33	$23.90	$23.90	$57.90	$75.10

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017

SilverScript Choice Premiums - By State

States	Region	SilverScript Choice 2018	SilverScript Choice 2017	SilverScript Plus 2018	SilverScript Plus 2017
Idaho	31	$32.70	$33.80	$76.30	$84.80
Illinois	17	$23.40	$28.40	$81.50	$85.40
Indiana	15	$23.40	$26.60	$46.30	$62.40
Iowa	25	$28.80	$31.30	$66.40	$73.30
Kansas	24	$24.50	$27.20	$72.20	$77.30
Kentucky	15	$23.40	$26.60	$46.30	$62.40
Louisiana	21	$23.10	$24.20	$54.90	$64.20
Maine	1	$29.60	$32.10	$52.20	$73.00
Maryland	5	$29.50	$33.90	$77.60	$81.90
Massachusetts	2	$29.40	$32.30	$63.80	$67.90
Michigan	13	$29.10	$33.50	$66.50	$70.20
Minnesota	25	$28.80	$31.30	$66.40	$73.30
Mississippi	20	$20.50	$25.00	$46.30	$61.30

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017

SilverScript Choice Premiums - By State

States	Region	SilverScript Choice 2018	SilverScript Choice 2017	SilverScript Plus 2018	SilverScript Plus 2017
Missouri	18	$24.10	$26.10	$46.20	$67.10
Montana	25	$28.80	$31.30	$66.40	$73.30
Nebraska	25	$28.80	$31.30	$66.40	$73.30
Nevada	29	$38.10	$39.40	$68.30	$72.20
New Hampshire	1	$29.60	$32.10	$52.20	$73.00
New Jersey	4	$34.30	$39.50	$84.60	$88.60
New Mexico	26	$18.50	$19.50	$39.80	$43.80
New York	3	$29.80	$30.80	$72.00	$75.70
North Carolina	8	$26.40	$29.30	$62.30	$68.70
North Dakota	25	$28.80	$31.30	$66.40	$73.30
Ohio	14	$24.00	$27.40	$46.30	$71.40
Oklahoma	23	$23.90	$28.10	$68.00	$71.90
Oregon	30	$30.40	$32.30	$69.10	$72.90

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017

SilverScript Choice Premiums - By State

States	Region	SilverScript Choice 2018	SilverScript Choice 2017	SilverScript Plus 2018	SilverScript Plus 2017
Pennsylvania	6	$27.80	$28.50	$72.00	$77.90
Rhode Island	2	$29.40	$32.30	$63.80	$67.90
South Carolina	9	$20.70	$25.20	$46.30	$63.00
South Dakota	25	$28.80	$31.30	$66.40	$73.30
Tennessee	12	$25.40	$28.90	$46.20	$68.90
Texas	22	$23.50	$27.50	$46.40	$56.30
Utah	31	$32.70	$33.80	$76.30	$84.80
Vermont	2	$29.40	$32.30	$63.80	$67.90
Virginia	7	$26.00	$30.80	$46.20	$74.20
Washington	30	$30.40	$32.30	$69.10	$72.90
West Virginia	6	$27.80	$28.50	$72.00	$77.90
Wisconsin	16	$34.60	$36.70	$68.50	$72.50
Wyoming	25	$28.80	$31.30	$66.40	$73.30

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017

2018 SilverScript Plus (PDP)

- SilverScript Plus – Members get everything the SilverScript Choice plan offers, plus enhanced coverage for Medicare's "donut hole."
  - **DEDUCTIBLE**: $0 deductible in all states.
  - **EXTRA GAP COVERAGE**: Tier 1 and Tier 2 medications have the same low copays in the Coverage Gap as before the Coverage Gap.
  - **PREMIUMS**: Low monthly premium.
    - Eleven states with monthly premiums under $50 (AL, GA, IN, KY, MO, MS, OH, SC, TN, TX, and VA)
  - **PHARMACY NETWORK**: The Plus Network includes more than 67,000 pharmacies and the CVS Caremark preferred mail service pharmacy.
    - The Plus Network includes over 35,000 Preferred retail pharmacies and over 32,000 Standard retail pharmacies.
    - Tier 1 & Tier 2 - Preferred Generic Tier and Generic Tier drugs have a $0 copay through our mail service pharmacy.
  - **FORMULARY**: Slightly different formulary than the SilverScript Choice formulary.

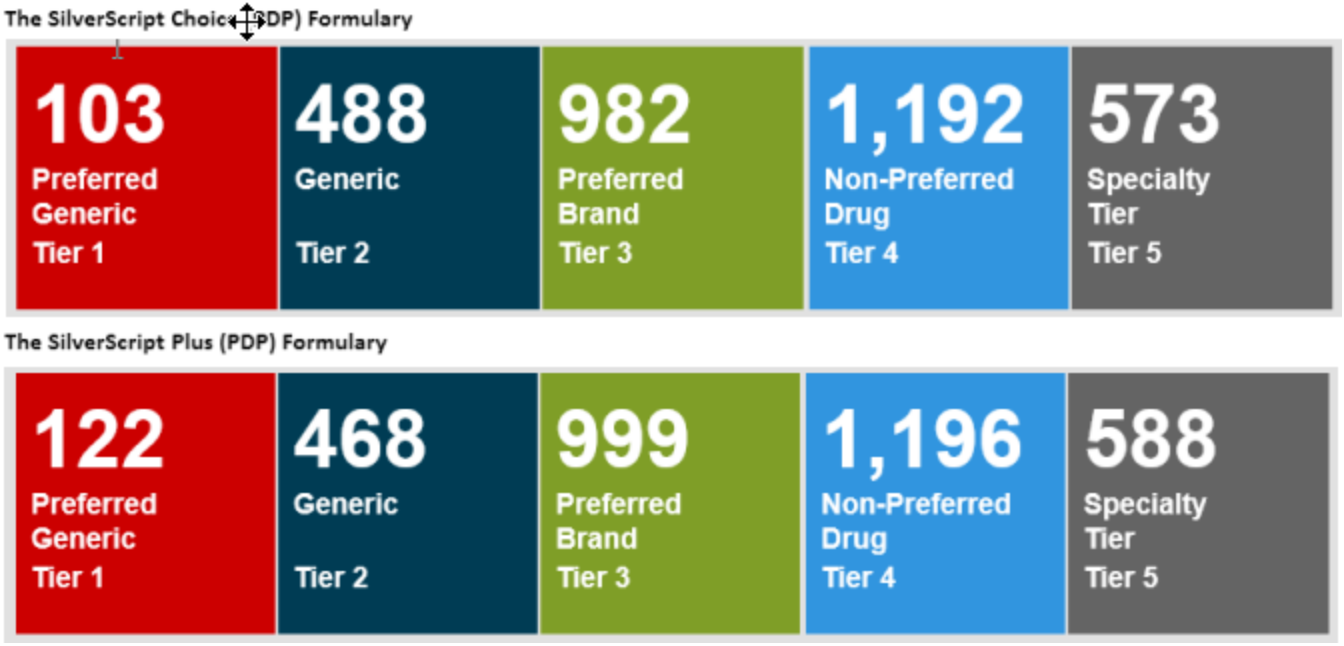
NOTE: SilverScript Plus PDP is not available in Alaska

2018 SilverScript Plus PDP Design - All States (not available in AK)

	SilverScript Plus			
Regions	Most Regions		AL, GA, IN, KY, MO, MS, OH, SC, TN, TX, VA	
Annual Deductible	$0 deductible applies to all tiers			
Initial Coverage (ICL)	**Retail Pharmacy Preferred / Standard**	**Mail Service Pharmacy Preferred**	**Retail Pharmacy Preferred / Standard**	**Mail Service Pharmacy Preferred**
	30-day	90-day	30-day	90-day
Tier 1	$1 / $10	$0	$2 / $10	$0
Tier 2	$5 / $20	$0	$8 / $20	$0
Tier 3	$35 / $47	$70	$40 / $47	$80
Tier 4	40% / 50%	40%	46% / 50%	46%
Tier 5	33% / 33%	N/A	33% / 33%	N/A
Coverage Gap (donut hole)	Members leave the ICL stage and enter the Medicare Coverage Gap when they have reached $3,750 in total yearly drug costs (not including monthly premiums)			
Tier 1	$1 / $10	$0	$2 / $10	$0
Tier 2	$5 / $20	$0	$8 / $20	$0
Tiers 3, 4, and 5	Generic drugs: Members pay 44% of the cost Brand drugs: Members pay 35% of the cost			
Catastrophic Coverage (after donut hole)	Members enter the Catastrophic Coverage stage when they have spent $5,000 out of pocket (not including monthly premiums) Generic drugs: Members pay the greater of 5% coinsurance or $3.35 copay All other drugs: Members pay the greater of 5% coinsurance or $8.35 copay			

Source: SilverScript Insurance Company Actuarial Services, as of August 1, 2017
Premiums and coinsurance vary by region to comply with CMS equivalence rules.

SilverScript 2018 Open PDP Formularies



All SilverScript formulary tiers include generic and brand drugs
Source: Formulary Management Department, August 3, 2017

Formulary Considerations

- SilverScript carefully reviews our formularies and makes changes from year to year.
- Overall drug counts are similar for both the SilverScript Choice formulary and the SilverScript Plus formulary compared to 2017 but there are changes.
- SilverScript removed drugs, added drugs, and even moved over 100 drugs to a lower cost tiers.
- Interesting fact: 8 out of SilverScript's Top 10 drugs utilized in 2017 by Choice members have a cost less than the copay. Remember, our members are automatically charged which ever is lower: the drug cost or the copay.

Drug Name	Tier	Cost Less Than Copay?
Amlodipine Besylate	1	Yes
Atorvastatin Calcium	1	No
Furosemide tabs	1	Yes
Lisinopril	1	Yes
Metformin HCL	1	Yes
Metoprolol Tartrate	1	Yes
Simvastatin	1	Yes
Gabapentin caps	2	Yes
Hydrocodone/Acetaminophen	2	No
Omeprazole DR	2	Yes

Note: Actual drug costs change frequently and vary by pharmacy
Source: SilverScript Insurance Company Med D Analytics, as of June 28, 2017

Formulary Considerations

- We recommend that agents use a drug pricing/plan comparison tool when reviewing PDP options with clients.
- The plan comparison tools use the "less than" logic to ensure the plan comparison includes the drug cost when it is lower than the tier copay.
- Even though some PDPs have a higher copay than other PDPs, the "less than" logic is an important reason why agents should run a plan comparison analysis for each client.
- Starting with the 2018 AEP, we will post on the SilverScript Agent Portal Reference Material's page a list of common medications with costs significantly less than the 2018 Choice PDP copay. This document will be a helpful resource for agents. Here is a chart showing some of those medications:

Drug Name	Drug Name	Drug Name
Alprazolam tab	Furosemide tab	Omeprazole cap
Atenolol tab	Gabapentin cap	Pantoprazole tab
Bisoprolol funarate/HCTZ tab	Hydrochlorothiazide tab	Prednisone tab
Buspirone tab	Lamotrigine tab	Ramipril cap
Carvedilol tab	Letrozole tab	Ranitidine tab
Chlorhexidine gluconate sol	Lisinopril/HCTZ tab	Simvastatin tab
Clonazepam tab	Lisinopril tab	SMZ/TMP DS tab
Clonidine tab	Lorazepam tab	Terazosin cap
Diazepam tab	Losartan/HCT tab	Terbinafine tab
Donepezil tab	Meloxicam tab	Timolol Maleate sol
Escitalopram tab	Methimazole tab	Toresemide tab
Famotidine tab	Mirtazapine tab	Tramadol HCL tab
Fosinopril tab	Omeprazole DR cap	Trazodone tab

Note: Actual drug costs change frequently and vary by pharmacy
Source: SilverScript Insurance Company Med D Analytics, as of June 28, 2017

Medicare Part B vs Part D Drugs

Medicare prescription drug plans are unable to cover drugs that would be covered under Medicare Part A or Part B

- Some drugs are covered under Medicare Part B in certain cases and under Medicare Part D in others
- Pharmacists and providers will appropriately determine whether to bill Medicare Part B or Part D for the drug
- Common questions include "Are diabetes supplies covered by Medicare Part D?"
    - Blood sugar (glucose) test strips, blood sugar testing monitors, lancet devices and lancets are typically covered by Medicare Part B

Pharmacy Network for SilverScript Choice

- SilverScript PDPs will be supported by two plan-specific pharmacy networks in 2018.
  - SilverScript Choice (PDP): SilverScript Choice network now distinguishes between preferred and standard pharmacies.

Source: CVS Health Networks Analytics, July 31, 2017
SilverScript Choice PDP pharmacy network offers limited access to pharmacies with preferred cost sharing in rural areas of AK and OK.

Simple Steps to Transfer Prescriptions to a Preferred Pharmacy

Members have several options on how to transfer their prescriptions to a preferred pharmacy

- Over the phone:
  - Members can call the SilverScript toll free number for CVS prescription transfers.
  - Members will speak with a specialist who will handle all of the details.
- Visit the new pharmacy:
  - Walk into the local pharmacy.
  - Pharmacy employees handle pharmacy transfers on a regular basis.

- Additional information on how members can transfer prescriptions to a preferred pharmacy will be available to agents on the SilverScript Agent Portal's Reference Materials page. The reference sheet will include the CVS prescription transfer toll free number and hours of operation.
- Care reps should check work instructions to properly handle member requests to transfer prescriptions to a preferred pharmacy.

Mail Service Pharmacies

CVS Caremark mail service pharmacy is the only preferred mail service pharmacy in network.

- SilverScript Choice members:
  - $0 copays by mail on Tier 1 drugs.
- SilverScript Plus members:
  - $0 copays by mail on Tier 1 and Tier 2 drugs.
- As always, there is no additional cost for standard delivery from our mail service pharmacy.
- It's easy for members to start mail service.
  - Members need a new 90-day prescription.
  - Members may call the toll free number on their SilverScript ID card.
  - Members may complete and submit the online mail service application at Caremark.com/faststart.
  - Members may complete the mail service order form included in their welcome kit.

Out of Network Information

- There are circumstances for which members can obtain benefit coverage for a covered drug that is not filled at a network pharmacy
- Out-of-network pharmacies might include home infusion therapy, long-term care facility pharmacies, and retail pharmacies that are not in the plan's network
- Instances where members will receive benefit coverage for a prescribed covered drug would include:
  - When members are traveling outside of your plan's service area
  - If members lose or run out of their covered drugs or become ill and need a covered drug immediately and cannot access a network pharmacy
  - If members cannot obtain a covered drug within their service area in a timely manner due to lack of availability of a participating network pharmacy
  - If members' covered drug is provided by an out-of-network institution-based pharmacy while they are in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting
  - If members are administered a vaccine covered by their plan in a physician's office
  - If members must fill a covered drug prescription and the drug is not regularly stocked at accessible network retail or mail service pharmacies

ExtraCare Health Card

- Effective 12/31/2017, SilverScript is discontinuing its relationship with the CVS Pharmacy ExtraCare Health Card program.

Star Ratings

- The Medicare program rates how well plans perform in different categories.
- The SilverScript plan rating information is included with the plan's enrollment kit.
- Ratings for all Medicare prescription drug plans are available directly from Medicare and you can obtain this information online at Medicare's website or by calling Medicare.
- Plan performance summary star ratings are assessed each year and may change from one year to the next.
- **Plan performance summary ratings are issued in October and reflect the previous plan contract year.**
  - **Enrollment kits fulfilled prior to November will reflect the previous year's star rating.**
  - **SilverScript will insert the updated star ratings sheet into the enrollment kits once the new ratings are released.**
    - **SilverScript will post an announcement on the SilverScript Agent Portal when new Star Ratings are released.**
    - **You should download the updated star ratings sheet from the SilverScript Agent Portal, print copies of the updated document, and replace the form that is in the remaining supply of kits you have in your office.**

SilverScript Agent Portal

- Interactive pharmacy locator
- Interactive drug coverage and pricing tools
- Online enrollment tool enabling you to key in your clients' applications knowing that the information is complete, accurate, and submitted promptly
- Enrollment status visibility and reports
- Downloadable Reference Materials
- User Guide with step-by-step instructions and screen shots

Interactive Drug Coverage and Pricing Tool

- Agents are able to estimate costs of prescription drugs that your prospects currently take or plan to take in the upcoming year.
- The tool provides:
  - Annual cost estimates for the SilverScript plans.
  - A monthly estimated budget showing drug cost, plan cost, member cost, and premium.
  - Drug price details for each stage of coverage (deductible, initial, gap, and catastrophic).
  - Printing options for reports that you can share with your prospects.
  - Ability to show analysis no matter which month the prospect's coverage will start.
  - Medicine Cabinet to store newly created searches.
    - Retrieve drug list by entering Member ID or Medicine Cabinet code.
- Agents MUST communicate the pricing tool disclaimer to prospects and clients.
  - Disclaimer appears at bottom of pricing tool pages.

Avoiding A Common Marketing Misrepresentation Complaint

- Medicare beneficiaries submit complaints and grievances to CMS, the plan, and even their elected officials.
- The most common SilverScript agent-related issues deal with the annual cost estimate.
- **When using a drug coverage and pricing tool, SilverScript agents are reminded to:**
  - Verify the drug name.
    - Many members think they are taking a brand name when they are actually taking a generic, and vice-versa.
  - Verify the dosage.
    - Make certain you are accurately entering the dosage on a daily or weekly or monthly basis.
      - 2 pills taken 2 times per day is a daily dosage of 4.
      - 1 pill taken 3 times per week is a weekly dosage of 3.
    - Confirm that you are entering a 30-day supply or a 90-day supply - this will have significant impact to the estimate and generates a large number of member complaints.
    - Be very careful when entering dosage for injectables, drops, and inhalers.
  - Communicate quantity limits and other disclaimers.
    - Some prescriptions are for short term use only, the pricing tool and formulary reference the restrictions.
    - Drug prices change.
      - Copays are fixed dollar amounts but co-insurance is a percent of the drug cost...if the drug cost changes, the member will pay a different amount if the drug is on a Tier with coinsurance.

Enrollment Process Overview

Call Center management will provide separate Enrollment Process training to Call Center Member Advocates

What to expect after submitting enrollments

- Acknowledgement Letter: The acknowledgement letter lets the member know that we received the enrollment application
- Confirmation Letter: The confirmation letter lets the member know that Medicare has approved the enrollment.
- Welcome Kit: The welcome kit contains important plan information including:
  - Welcome Brochure - an introduction to the 2017 SilverScript plan
  - Membership ID Card
  - Low Income Subsidy (LIS) Rider
  - Evidence of Coverage - a document that explains how the plan works, how we protect the member's privacy, and how to apply for Extra Help
  - Abridged Formulary - a partial list of prescription drugs covered by the plan
  - Pharmacy Directory - an updated listing of network pharmacies in the member's area

Premium Billing Information

- Members can pay the monthly plan premium (including any late enrollment penalty) by mail, automatic bank draft withdrawal, automatic deduction from monthly Railroad Retirement Board check, automatic deduction from Social Security benefit check, or credit card
- If a member is assessed a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), the member will be notified by the Social Security Administration. Part D-IRMAA is not paid to SilverScript
- Automatic Bank Draft Withdrawal from Checking or Savings Account
  - The member's bank will pay SilverScript through electronic bank withdrawal
- Automatic Deduction from Social Security or Railroad Retirement Board benefit check
  - Automatic deduction may take several months to begin
  - Members are responsible for paying the monthly premiums until the agency accepts the deduction request
  - If the automatic deduction is not approved, then SilverScript will send monthly bills
- Monthly payments by personal check
  - SilverScript will send an invoice each month - SilverScript bills prospectively (example, sends bill in December for January coverage)
  - If your client elects to have his/her premium automatically deducted via social security, it may take two or more months to begin

Eligibility and Enrollment in a Part D Plan

- In general, an individual is eligible to enroll in a Medicare prescription drug Part D plan if:
  - The individual is entitled to Medicare Part A and/or enrolled in Part B
  - The individual has current Part D eligibility in CMS systems; and
  - The individual permanently resides in the service area of a PDP
- An individual who is living abroad or is incarcerated (irrespective of where this is) is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan

Eligibility and Enrollment in a Part D Plan

- A Part D eligible individual may not be enrolled in more than one Part D plan at the same time. A Part D eligible individual may not be simultaneously enrolled in a PDP and a Medicare Advantage (MA) plan except for a MA Private Fee-For-Service (PFFS) plan that does not offer the Part D benefit, a Medicare Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority
- The PFFS exception is applied at the plan level (i.e. the PBP or “plan benefit package” level). An individual enrolled in an MA PFFS plan that does not offer Part D may enroll in a stand-alone PDP, even if the same MA organization offers other plans (including PFFS plans) that include a prescription drug benefit

Enrollment and Disenrollment Periods and Effective Dates

- There are 3 periods in which an individual may enroll in and/or disenroll from a PDP:
  - The Initial Enrollment Period for Part D (IEP for Part D)
  - The Annual Coordinated Election Period (AEP)
  - All Special Enrollment Periods (SEP)
- During the AEP, individuals may enroll in and disenroll from a PDP plan, or choose another PDP plan
- Depending on the SEP, an individual may be limited to enrolling in or disenrolling from a PDP plan
- Individuals may enroll in a PDP during the IEP for Part D. Each individual has one election per enrollment period; once an enrollment or disenrollment becomes effective, the election has been used
- All PDP sponsors must accept enrollments into their PDP plans during the AEP, an IEP for Part D, and an SEP. PDP enrollment periods coordinate with similar periods in Medicare Advantage to accommodate enrollment in MA-PDs
- The last enrollment or disenrollment choice made during an enrollment period, (except for SEPs – beneficiaries get only one chance) determined by the application date a request was received by the PDP sponsor, will be the choice that becomes effective

When Can Beneficiaries Join, Switch, or Drop a Medicare Drug Plan?

- Annual Coordinated Election Period (AEP)
  - During AEP beneficiaries may enroll for the first time or switch plans
  - The AEP for 2018: October 15, 2017 – December 7, 2017
  - Coverage will begin on January 1, 2017 as long as the plan gets the enrollment request by December 7
- Initial Enrollment Period (IEP)
  - When beneficiaries are first eligible for Medicare
  - The 7 month period that begins 3 months before the month beneficiaries turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65
- Enrollment requests made PRIOR to the month of eligibility are effective the first day of the month of eligibility
- Enrollment requests made DURING or AFTER the first month of eligibility are effective the first of the month following the month the request was made
- An SEP exists for members of a PDP that will be affected by a plan or contract non-renewal that is effective January 1 of the contract year. For this type of non-renewal, PDP sponsors are required to provide advance notice to affected members within timeframes specified by CMS. In order to provide sufficient time for members to evaluate their options, the SEP begins December 8 and ends on the last day in February of the following year
- Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1

When Can Beneficiaries Join, Switch, or Drop a Medicare Drug Plan?

- In most cases, beneficiaries must stay enrolled for that calendar year starting the date the coverage begins; however, in certain situations, beneficiaries may be able to join, switch, or drop Medicare drug plans during the plan year if they qualify for a special enrollment period
- Here are some of the situations in which a beneficiary will qualify for a Special Election Period (SEP):
  - Moving outside the plan's region
  - Gaining/losing (voluntarily or involuntarily) employer coverage
  - If the plan's CMS contract non-renewal or termination
  - Disenrolling from the Program of All Inclusive Care for the Elderly (PACE)
  - Low Income Subsidy (LIS) enrollee
  - Released from incarceration
  - Lost creditable coverage
  - Living in an institution
  - If the member wants to enroll in a plan with a 5 star rating
  - Coordinating with MA enrollment periods

Special Rule for the Annual Coordinated Election Period (AEP)

- Brokers and agents under contract to PDP sponsors may not accept or solicit submission of paper enrollment forms prior to October 1
- PDP sponsors and their brokers and agents also should remind beneficiaries that they cannot submit enrollment requests prior to the start of the AEP

Effective Date of Enrollment

- With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not request their effective date of enrollment in a PDP. Furthermore, unless provided for under an SEP, the effective date can never be prior to the receipt of an enrollment request by the PDP sponsor. An enrollment cannot be effective prior to the date the beneficiary (or their legal representative, if applicable) completed the enrollment request
- To determine the proper effective date, the PDP sponsor must determine which enrollment period applies to each individual before the enrollment may be transmitted to CMS. This period may be determined by reviewing information such as the individual's date of birth, Medicare card, and by the date the PDP sponsor receives the enrollment request

Who May Complete an Enrollment Request

- Only the beneficiary or his or her authorized representative as determined under state law may request an enrollment. CMS will recognize State laws that authorize persons to effect a Part D enrollment or disenrollment request for Medicare beneficiaries. Persons authorized under State law may include court-appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity
- When an authorized representative completes an enrollment request on behalf of a beneficiary, the PDP sponsor should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes

When the Enrollment Request Is Incomplete

- For incomplete IEP enrollment requests received prior to the month of entitlement to Part A or enrollment in Part B, additional documentation to make the request complete must be received during the first three months of the IEP, or within 21 calendar days of the request for additional information (whichever is later). For incomplete IEP enrollment requests received during the month of entitlement to Part A or enrollment in Part B or later, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later)
- For incomplete AEP elections, additional documentation to make the request complete must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later)
- **If additional documentation needed to make the request complete is not received within the CMS stipulated timeframes, the organization must deny the enrollment request**
    - SilverScript encourages agents to review the Reports section of the SilverScript Agent Portal to identify any clients with applications that "Need Correction" or have not been approved. Agents should reach out to the clients and remind them to contact SilverScript directly to resolve enrollment application issues
- If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must contact the individual to confirm that the individual lives in the service area

Proof of Creditable Coverage

- When SilverScript submits a beneficiary's enrollment to CMS, CMS may come back to us with information about 'uncovered months' (i.e. months for which the beneficiary was eligible for Part D but did not have creditable coverage) for which the beneficiary may be assessed a late enrollment penalty (LEP)
- Upon receiving this information from CMS, SilverScript sends a letter to the beneficiary requesting him/her to provide SilverScript with proof of 'creditable coverage' (or an attestation) if they want to avoid the LEP
- If your client receives this letter from SilverScript requesting proof of 'Creditable Coverage', he/she should promptly act on that letter to avoid the late enrollment penalty (LEP)
- **Even if you or your client had already submitted proof of creditable coverage with the enrollment application, please call the number on the letter and confirm this information or mail the requested proof to the number/address specified in the letter**

Income Related Monthly Adjustment Amounts (Part D-IRMAA)

- Before consideration of premium adjustments based on income, Part D enrollee premiums vary from plan to plan.
- If a beneficiary's "modified adjusted gross income" is greater than the specified threshold amounts ($85,000 in 2018 for a beneficiary filing an individual income tax return or married and filing a separate return, and $170,000 for a beneficiary filing a joint tax return), then the beneficiary is responsible for a larger portion of the total cost of Part D benefit coverage.
- In addition to the normal Part D premium paid to a plan, such beneficiaries must pay an income-related monthly adjustment amount.
- Unlike the normal Part D premium, beneficiaries will not pay the Part D income-related monthly adjustment amounts to Part D plans. Instead, the Part D income-related monthly adjustment amounts will be collected by the federal government.
- Shown in the following table are the 2018 Part D income related monthly adjustment amounts to be paid by beneficiaries who file individual tax returns (including those who are single, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year), or who file joint tax returns:

Income Related Monthly Adjustment Amounts (Part D-IRMAA)

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file separate returns from their spouses and lived with their spouses at any time during the taxable year, are as follows:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Applicable Percentage	Part D income-related monthly adjustment amount
Less than or equal to $85,000	Less than or equal to $170,000	N/A	$0.00
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	35%	$13.00
Greater than $107,000 and less than or equal to $133,500	Greater than $214,000 and less than or equal to $267,000	50%	$33.60
Greater than $133,500 and less than or equal to $160,000	Greater than $267,000 and less than or equal to $320,000	65%	$54.20
Greater than $160,000	Greater than $320,000	80%	$74.80

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file separate returns from their spouses and lived with their spouses at any time during the taxable year, are as follows:

Beneficiaries who are married but file separate tax returns from their spouses, with income:	Part D income-related monthly adjustment amount
Less than or equal to $85,000	$0.00
Greater than $85,000	$74.80

Late Enrollment Penalty

- The late enrollment penalty is an amount that is added to a beneficiary's Part D premium.
- By Law, beneficiaries who do not join a plan when they were first eligible for Medicare and go 63 days or more without any other creditable coverage (i.e. coverage at least as good as Part D) will be penalized 1% of the national base beneficiary premium per month for every month they were eligible to join and did not. This penalty will be charged as long as the beneficiaries are enrolled in Medicare Part D. This is known as the late enrollment penalty (LEP).
- The Part D base beneficiary premium for 2018 is $35.02 (1% equals $0.3502)
- The member may owe a late enrollment penalty if one of the following is true:
  - The beneficiary didn't join a Medicare drug plan when first eligible for Medicare, and didn't have other creditable prescription drug coverage.
  - The Beneficiary had a break in Medicare prescription drug coverage or other creditable coverage of at least 63 days in a row.
- Note: Beneficiaries receiving Extra Help from the government don't pay a late enrollment penalty.

Enhanced Medication Therapy Management Program

- SilverScript has applied to participate in a CMS Model Test regarding enhanced medication therapy management services (Enhanced MTM) in accordance with a proposal approved by CMS, which will include the following elements:
  a. Targeting: This component includes strategies to identify enrollees at risk for medication-related issues. Examples of targeting strategies may include transitions of care, beneficiary annual Medicare spending, prescription of certain types of medication, and other criteria.
  b. Engagement: This component includes methods for interacting with beneficiaries to solicit active participation in medication therapy management in order to determine their obstacles to effective medication usage. Examples of engagement methods may include telephone outreach, community pharmacist interactions, written materials, online educational materials, and other approaches.
  c. Interventions: This component includes the provision of services designed to overcome an identified obstacle to effective medication usage. Examples of interventions may include pharmacy consultations, medication therapy reminders, provision of cost sharing assistance, medication review, or other services.
- For purposes of communicating any information related to the Model Test, SilverScript shall comply with the following:
  a. The PDP Sponsor and its representatives shall not disclose the PDP Sponsor's participation in the Model Test to a Potential Enrollee unless the Potential Enrollee or his or her authorized representative makes an inquiry about the Model Test or the availability of MTM services under the plan.
  b. If a Potential Enrollee or his or her authorized representative makes a specific inquiry about MTM services or the Model Test, the PDP Sponsor must convey truthful and accurate information about the Enhanced MTM available to enrollees under the Model Test and must convey that eligibility is determined after enrollment and is not assured.

Non-Discrimination Requirements

- Plans/Part D Sponsors may not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location. All items and services of a plan sponsor are available to all eligible beneficiaries in the service area with the following exceptions:
  - Certain products and services may be made available to enrollees with certain diagnoses (e.g., medication therapy management program for individuals with chronic illnesses or medically necessary coverage provisions)
  - Enrollment in the low income subsidy (LIS), as there may be additional eligibility standards
- Plan sponsors may not engage in discriminatory practices such as:
  - Targeting marketing to beneficiaries from higher income areas
  - Stating or otherwise implying that plans are available only to seniors rather than to all Medicare beneficiaries
- Only organizations offering SNPs may limit enrollment to dual-eligibles, institutionalized individuals, or individuals with severe or disabling chronic conditions and/or may target items and services to corresponding categories of beneficiaries
- Materials in alternate formats are available upon request. Your clients should contact SilverScript customer care to request the materials directly

Overview of MA Disenrollment

- There are two types of MA disenrollment
  - Voluntary disenrollment
    - Enrollees choose to leave a plan because they want to leave
  - Involuntary disenrollment
    - In certain situations, the plan may be required (or may have the option) to end an enrollee's membership
- MA Disenrollment periods
  - When enrollees changes coverage, they are ending membership in their current plan
  - There are only certain times during the year when enrollees may voluntarily change/end their membership in a plan:
    - Annual Election Period
    - MA Disenrollment Period (MADP January 1 - February 14)
- Special Enrollment Period
- **The MA Disenrollment Period is an opportunity to market SilverScript PDPs to beneficiaries wishing to leave an MAPD, return to Original Medicare and enroll in a stand-alone PDP**

Overview of PDP Disenrollment

- There are two types of PDP disenrollment
  - Voluntary disenrollment
    - Enrollees choose to leave a plan because they want to leave
  - Involuntary disenrollment
    - In certain situations, the plan may be required (or may have the option) to end an enrollee's membership
- PDP Disenrollment periods
  - When enrollees changes coverage, they are ending membership in their current plan
  - There are only certain times during the year when enrollees may voluntarily change/end their membership in a plan:
    - Annual Election Period
    - Special Enrollment Period

Voluntary Disenrollment: PDP

- The key time, but not the only time, to voluntarily change prescription drug plans is during the AEP
- To enroll in a new PDP
  - Simply enroll in the new plan – CMS will generate a disenrollment to the prior plan based on the effective date of coverage in the new plan
- There are a few exceptions to automatic disenrollment from PDP plans
  - If enrollees are joining an MA PFFS that does not offer drug coverage
  - If enrollees are joining an MSA plan
  - If enrollees are not joining any other Medicare health or prescription drug plan
  - To disenroll in one of these situations, enrollees (not the agents) should:
    - Submit written disenrollment request to their current plan or
    - Call Medicare to request disenrollment
- Submitting voluntary disenrollments
- NOTE: Agents cannot submit disenrollments on behalf of their clients. The member must send a written disenrollment request to SilverScript (or enroll in a different plan)

Voluntary Disenrollment: MA and MA-PD

- To voluntarily disenroll in an MA or MA-PD and enroll in:
  - An MA plan - enrollees should simply enroll in the new MA plan. Disenrollment will be automatic when the new coverage begins
  - Original Medicare and a PDP – enrollees should simply enroll in the new PDP. Disenrollment will be automatic when the new coverage begins
  - Original Medicare without a PDP – Submit written disenrollment request to current plan or call Medicare to request disenrollment
- There are a few exceptions to disenrolling from MA and MA-PD plans:
  - If enrollees are leaving an MSA plan, enrollees should contact the plan's member services number to disenroll, enrollees cannot disenroll by calling Medicare
- If enrollees in a PFFS plan without prescription drug coverage want to switch to Original Medicare, enrollees should contact the PFFS plan's member services to request disenrollment or contact Medicare to request disenrollment

Voluntary Disenrollment: Medicare Cost Plans

- Enrollees may end their membership in a Medicare Cost Plan at any time during the year and enroll in Original Medicare
- Membership will end on the first of the month after the plan receives a written request to disenroll
- To disenroll enrollees must submit a written request to the plan, they cannot disenroll by calling Medicare
- If enrollees disenroll from a Medicare Cost Plan with drug coverage, they will have the opportunity to join a Medicare PDP when they leave

Voluntary Disenrollment: MSA Plans

- There are specific guidelines to protect the funds in an MSA plan
  - If enrollees leave an MSA plan or is involuntarily disenrolled in the middle of the year, part of the most recent deposit (based on the number of months left in the current calendar year) will be refunded to Medicare
  - Funds remaining in the enrollees' accounts from the previous year belong to the enrollees
  - Recovery applies only to funds deposited into the enrollees' accounts for the current year
- If the enrollees have any questions about this, they will need to contact the plan's member services department

Involuntary PDP Disenrollment by the Plan Sponsor

- Optional involuntary disenrollment
  - A PDP sponsor may disenroll an individual from a PDP it offers in any of the following circumstances:
    - Any monthly premium is not paid on a timely basis
    - The individual has engaged in disruptive behavior
- Required involuntary disenrollment
  - A PDP sponsor must disenroll an individual from a PDP it offers in any of the following circumstances:
    - The individual no longer resides in the PDP's service area (or is incarcerated for more than 30 days)
    - The individual loses eligibility for Part D
    - Death of the individual
    - The individual materially misrepresents information to the PDP sponsor
    - The member fails to pay Part D-IRMAA to the government
    - The PDP sponsor's contract is terminated by CMS or by a PDP or through mutual consent
- The individual materially misrepresents information, as determined by CMS, to the PDP sponsor that the individual has or expects to receive reimbursement for third-party coverage.

Involuntary Disenrollment: Enrollees' Rights

- A plan is NOT allowed to end enrollees' membership:
  - For any reason related to enrollees' health (for all plan types except SNPs)
  - If enrollees ever feel that they are being encouraged or asked to leave a plan because of their health, enrollees should call the national Medicare help line
- Enrollees in all plan types have the right to make a complaint if the plan ends their membership
- If a plan ends enrollees' membership, the plan will tell enrollees the reason in writing and explain how enrollees may file a grievance against the plan

A Message Regarding SilverScript's Medicare Part D Compliance Training

- Compliance is **EVERYONE'S** responsibility!
- A culture of compliance within an organization:
  - Prevents non-compliance
  - Detects non-compliance, and
  - Corrects non-compliance
- **Ethics: Do the right thing!**
  - Act fair and honestly
  - Comply with the letter and the spirit of the law
  - Adhere to high ethical standards in all that you do
  - Report suspected violations

Everyone is required to report violations of Standards of Conduct and suspected non-compliance

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report

What is Non-Compliance?

- Non-compliance is conduct that does not conform to the law, State and Federal health care program requirements, or to an organization's ethical and business policies

Code of Conduct

- CMS requires that plan sponsors have in place or will implement a plan which includes adoption of a code of conduct, to detect, prevent and correct fraud, waste and abuse in the delivery of its services
- Agents need to receive a copy of CVS' Code of Conduct and will at all times act in a manner consistent with this Code of Conduct. The Code of Conduct is an exhibit within the current agent agreements. **The current Code of Conduct is also available for viewing/download via the SilverScript Agent Portal's Reference Material tab**

SilverScript Compliance Resources

- Feel free to contact the SilverScript Agent Support team or the Medicare Part D Compliance Department using any of the means noted below if you are unsure of the answer to a question, want verification on a process, or need some direction on a compliance topic.

SilverScript Agent Support
888-277-4174 or Producer.SalesResource@CVSCaremark.com

The CVS Caremark Ethics Line:
877-287-2040 or Ethics.BusinessConduct@cvs.com

Patrick Jeswald, Chief Compliance Officer, SSIC Med D
480-661-2030 or Patrick.Jeswald@cvshealth.com

Michael Nickelsburg, Sr. Manager, Compliance / Fraud, Waste & Abuse
480-661-2317 **or michael.nickelsburg@cvshealth.com**

Summary

CMS provided PDP sponsors with guidelines to use in developing their curricula for training and testing agents and brokers for calendar year 2018. The goal of CMS is to ensure that all agents and brokers selling Medicare products have a comprehensive and consistent understanding of Medicare rules.

This section was designed to provide you with an understanding of the following:

- SilverScript Insurance Company – the organization & our key differentiators
- SilverScript PDP benefit designs for 2018
- What you must do before you can sell for SilverScript
- Enrollment and disenrollment guidance
- CVS Caremark Code of Conduct and SilverScript compliance resources
- Call Center colleagues receive separate enrollment processing instructions and training