2019 Annual Certification

Medicare Basics and Beneficiary Rights Course

Updated June 29, 2018

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 your agency and 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.

Once you pass all courses:

- We will send you an initial supply of marketing materials (2019 kits begin shipping in mid-September).
- You will be permitted to view plan offerings and sell SilverScript prescription drug plans.

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 upline admin team. They are ready to support you.
- We have placed copies of the training courses on the SilverScript Agent Portal under Reference Materials for your reference.
- Feel free to print the training materials and reference them as you take the certification test.
- You must pass each course within three attempts to sell SilverScript Medicare Part D plans.
- We want you to be well informed as you sell our PDPs.
- 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.

Course Objective

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

- Overview of Medicare
- Overview of Medicare Advantage Health Plans
- Overview of Other Plan Types
- Overview of Medicaid
- Overview of Medigap
- Overview of Medicare Prescription Drug Coverage
- Beneficiary Rights

Medicare Parts and Covered Services

Medicare is health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of any age with End-Stage Renal Disease - ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

There are 4 different types of Medicare:

Part A, Part B, Part C and Part D

- **Medicare Part A** (Hospital Insurance) helps cover: inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.
- **Medicare Part B** (Medical Insurance) helps cover: services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.
- **Medicare Part C** (Medicare Advantage - known as MA): includes all benefits and services covered under Part A and Part B, usually includes Medicare prescription drug coverage (MA-PD), as part of the plan, run by Medicare-approved private insurance companies, and may include extra benefits and services for an extra cost.
- **Medicare Part D** (Medicare Prescription Drug Coverage - known as PDP): helps cover the cost of prescription drugs, run by Medicare-approved private insurance companies, and may help lower beneficiary's prescription drug costs and help protect against higher costs in the future.

Descriptions of Medicare Options

Original Medicare – also called Fee-for-Service

- Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system
- Run by the federal government

Medicare Advantage – also called Medicare Part C or MA

- Covers Part A and B services and usually prescription drug coverage
- Sometimes includes additional benefits such as dental and vision insurance
- Run by private insurance companies

Medicare Part D (MA-PDs and PDPs)

- People who are enrolled in Medicare can add a stand-alone PDP to Original Medicare or to Medicare Advantage plans that don't offer drug coverage – such as Medical Savings Accounts, certain Private Fee-for-Service plans and Medicare Cost Plans.
- MA-PD is the drug component of the MA plans that offer drug coverage.

Medicare Basics:
Some People Get Part A and Part B Automatically

Individuals may qualify for Part A and Part B if one of the following applies:

- Already getting benefits from Social Security or the Railroad Retirement Board (RRB).
    - In most cases, individuals will automatically get Part A and Part B starting the first day of the month they turn 65.
    - If the birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.
- Under 65 and have a disability.
    - People automatically get Part A and Part B after they get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.
- Have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease).
    - People automatically get Part A and Part B the month the disability benefits begin.
- Live in Puerto Rico and get benefits from Social Security or the RRB.
    - People automatically get Part A.
    - If they want part B, they need to sign up for it.

People who get Medicare automatically, will receive their red, white, and blue Medicare card in the mail 3 months before their 65th birthday or their 25th month of disability.

Medicare Basics:
Some People Need To Sign Up For Part A and Part B

People need to sign up for Part A and Part B if:

- They are not getting Social Security or RRB benefits (for example, because they're still working).
- They qualify for Medicare because they have ESRD.
- They live in Puerto Rico and want to sign up for Part B.

Medicare Basics:
Some People Need To Sign Up For Part A and Part B

People can sign up for Part A & Part B only at certain times.

- When they first get Medicare
  - People have a 7-month Initial Enrollment Period to sign up for Part A and Part B.
  - In most cases, if people don't sign up for Medicare Part B when they're first eligible, they'll have to pay a late enrollment penalty for as long as they have Part B and could have a gap in their health coverage.
- Between January 1 - March 31 each year
  - If they didn't sign up for Part A and/or Part B (for which they must pay premiums) when they were first eligible, and they aren't eligible for a Special Enrollment Period (see below), people can sign up during the General Enrollment Period between January 1–March 31 each year.
  - The coverage will start July 1. These people may have to pay a higher premium for late enrollment in Part A and/or a higher premium for late enrollment in Part B.
- Special circumstances (Special Enrollment Periods)
  - Once the Initial Enrollment Period ends, people may have the chance to sign up for Medicare during a Special Enrollment Period. If they're covered under a group health plan based on current employment, they have an SEP to sign up for Part A and/or Part B any time as long as they or a spouse (or family members if they're disabled) is working, and they're covered by a group health plan through the employer or union based on that work.
  - They also have an 8-month SEP to sign up for Part A and/or Part B that starts the month after the employment ends or the group health plan insurance based on current employment ends, whichever happens first. Usually, they don't pay a late enrollment penalty if they sign up during an SEP.

Medicare Part A Premiums

- Most individuals are eligible for premium-free Part A if they are age 65 or older and they or a spouse worked and paid Medicare taxes for at least 10 years.
- Individuals can get Part A at age 65 without having to pay premiums if the person:
    - Is receiving retirement benefits from Social Security or the Railroad Retirement Board.
    - Is eligible to receive Social Security or Railroad benefits but has not yet filed for them.
    - Or a spouse had Medicare-covered government employment.
- Individuals (or a spouse) who did not pay Medicare taxes while working, and who are age 65 or older and a citizen or permanent resident of the United States, may be able to buy Part A. In 2018, people who had to buy Part A paid premiums up to $422 each month. Visit Medicare.gov to find out the amount for 2019.
- Individuals who are under age 65 can get Part A without having to pay premiums if the person:
    - Has been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months (Note: If the person has Lou Gehrig's disease, then Medicare benefits begin the first month of disability benefits).
    - Is a kidney dialysis or kidney transplant patient.

Medicare Part B Premiums, Deductible and Coinsurance

People pay a premium each month for Part B.

- People who get Social Security, Railroad Retirement Board, or Office of Personnel Management benefits, have their Part B premium automatically deducted from the benefit payment.
- People who don't get these benefits are sent a bill.

Most people will pay the standard premium amount.

- If their modified adjusted gross income as reported on their IRS tax return from 2 years ago is above a certain amount, people may have an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to the premium.

The standard Part B premium amount in 2018 is $134 (or higher depending on income).

People will pay a different amount if:

- They enroll in Part B for the first time in 2018.
- They don't get Social Security benefits.
- They are directly billed for their Part B premiums.
- They have Medicare and Medicaid, and Medicaid pays the premiums.
- Their modified adjusted gross income as reported on their IRS tax return from 2 years ago is above a certain amount.

There is a Part B deductible and coinsurance.

- People pay $183 for their Part B deductible.
- After the deductible is met, people typically pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment.

Overview of Medicare Advantage Plans

Medicare Advantage (MA) or Medicare Part C plans

- MA plans are health plans for beneficiaries who are part of the Medicare program.
- MA began in December 2003, replacing the Medicare + Choice program, as a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
- MA plans are offered by private insurance companies that are approved by Medicare.
- MA plans are available in most (but not all) areas of the country.
- Beneficiaries who enroll in MA plans generally get all of their health care coverage through that plan.
- Many MA plans, except Medical Savings Accounts, include Part D prescription drug coverage.
- In addition to the Part B premium, beneficiaries usually pay one monthly premium for the services provided.
- All MA plans must:
  - Cover all Part A and Part B benefits.
  - Provide plan cost-sharing actuarially equivalent to cost sharing under Medicare Parts A and B, but may be different for specific services.
  - Include an annual maximum out-of-pocket (MOOP) limit on total enrollee cost sharing for Part A and Part B services.

Medicare Advantage Plan Types

There are different types of Medicare Advantage plans.

- Health Maintenance Organizations - HMOs (some include Part D)
- Preferred Provider Organizations - PPOs (some include Part D)
- Private Fee-for-Service - PFFS (some include Part D)
- Special Needs Plans - SNPs (always include Part D)
- Medical Savings Account plans - MSAs (do not include Part D)

There are other types of Medicare health plans.

- Medicare Cost and PACE plans (may include Part D)
- Demonstration and Pilot programs
- Employer or Union Group plans (some include Part D)

Health Maintenance Organizations (HMOs)

- Includes a network of providers.
- Members must stay in network or may pay full cost of services (except for emergency care, out-of-area urgent care, and out-of-area dialysis).
- Member must select a primary care physician.
- Member generally needs a referral to see a specialist.
- Plan covers Medicare Part A and Part B services.
- Some plans cover prescription drugs.
- Additional covered services may include vision, hearing, and wellness.
- POS option allows member to go outside of network but for a higher cost.

Health Maintenance Organization (HMO) General Details

Can members get their health care from any doctor, other health care provider, or hospital?

- No. Members generally must get their care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).
- In some plans, members may be able to go out-of-network for certain services, usually for a higher cost.
    - This is called an HMO with a point-of-service (POS) option.

Are prescription drugs covered?

- In most cases, yes. If members want Medicare drug coverage, they must join an HMO plan that offers prescription drug coverage.

Do members need to choose a primary care doctor?

- In most cases, yes. Check with the plan for more information.

Do members have to get a referral to see a specialist?

- In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral. Check with the plan for more information.

What else do members need to know about this type of plan?

- If their doctors or other health care providers leaves the plan, their plan will notify them. They must choose another doctor in the plan.
- If members get health care outside the plan's network, they may have to pay the full cost.
- It's important that members follow the plan's rules, like getting prior approval for a certain service when needed.

Preferred Provider Organization (PPO) General Details

Can members get their health care from any doctor, other health care provider, or hospital?

- In most cases, yes. PPOs have network doctors, other health care providers, and hospitals, but members can also use out-of-network providers for covered services, usually for a higher cost. Check with the plan for more information.

Are prescription drugs covered?

- In most cases, yes. If members want Medicare drug coverage, they must join a PPO plan that offers prescription drug coverage.

Do members need to choose a primary care doctor?

- No.

Do members have to get a referral to see a specialist?

- In most cases, no. Check with the plan for more information.

What else do members need to know about this type of plan?

- PPO plans aren't the same as Original Medicare or Medigap.
- Medicare PPO plans usually offer more benefits than Original Medicare, but members may have to pay extra for these benefits.

Private Fee-for-Service (PFFS) General Details

Can members get their health care from any doctor, other health care provider, or hospital?

- Members 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.
- If Medicare beneficiaries join a PFFS plan that has a network, the member can also see any of the network providers who've agreed to always treat plan members. Members can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but members may pay more. Check with the plan for more information.

Are prescription drugs covered?

- Sometimes. If the PFFS plan doesn't offer drug coverage, members can join a Medicare Prescription Drug Plan (Part D) to get coverage.

Do members need to choose a primary care doctor?

- No.

Do members have to get a referral to see a specialist?

- No.

What else do members need to know about this type of plan?

- PFFS plans aren't the same as Original Medicare or Medigap.
- The plan decides how much members must pay for services.
- Some PFFS plans contract with a network of providers who agree to always treat members even if they've never seen the member before.
- Out-of-network doctors, hospitals, and other providers may decide not to treat plan members even if they've seen the member before.
- In an emergency, doctors, hospitals, and other providers must treat plan members.

Special Needs Plans (SNP) General Details

Can members get their health care from any doctor, other health care provider, or hospital?

- Members generally must get their care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).

Are prescription drugs covered?

- Yes. All SNPs must provide Medicare prescription drug coverage (Part D).

Do members need to choose a primary care doctor?

- Generally, yes.

Do members have to get a referral to see a specialist?

- In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral. Check with the plan for more information.

What else do members need to know about this type of plan?

- A plan must limit membership to these groups: 1) people who live in certain institutions (like nursing homes) 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 (like diabetes, ESRD, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Plans should coordinate the services and providers its members need to help members stay healthy and follow doctor's or other health care provider's orders.

Other Types of Medicare Health Plans - Medicare Cost Plans

- Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare.
- Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.
    - **Medicare Cost Plans** - a type of Medicare health plan available in certain areas of the country.
        - Medicare beneficiaries can join even if they only have Part B.
        - If they have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. Members would pay the Part A and Part B coinsurance and deductibles.
        - Medicare beneficiaries can join anytime the Cost Plan is accepting new members.
        - Members can leave anytime and return to Original Medicare.
        - Members can either get their Medicare prescription drug coverage from the Cost Plan (if offered), or they can join a Medicare Prescription Drug Plan.

Other Types of Medicare Health Plans - PACE

- Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare.
- Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.
    - **Programs of All-inclusive Care for the Elderly (PACE)** - a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community.
        - To qualify for PACE, people must meet these conditions:
            - Be 55 or older.
            - Live in the service area of a PACE organization.
            - Be certified by the state as needing a nursing home-level of care.
            - At the time of joining, be able to live safely in the community with the help of PACE services
        - PACE provides coverage for many services, including prescription drugs, doctor or other health care practitioner visits, transportation, home care, hospital visits, and even nursing home stays whenever necessary.
        - If members have Medicaid, they won't have to pay a monthly premium for the long-term care portion of the PACE benefit.
        - If they have Medicare but not Medicaid, they will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE, there's never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Other Types of Medicare Health Plans - Medicare Innovation Projects

- Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare.
- Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.
    - Medicare Innovation Projects - Medicare develops innovative models, demonstrations, and pilot projects to test and measure the effect of potential changes in Medicare.
    - These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only for a limited time for a specific group of people and/or are offered only in specific areas.
    - Some examples include certain Accountable Care Organizations.

General Provisions of Medicare Advantage Plans

What are Medicare Advantage plans?

- A Medicare Advantage plan (like an HMO or PPO) is another way to get Medicare coverage.
- Medicare Advantage plans, sometimes called "Part C" or "MA Plans," are offered by private companies that Medicare approves.
- People who join a Medicare Advantage plan, still have Medicare but they get their Part A and Part B coverage from the Medicare Advantage plan, not Original Medicare.
- Medicare Advantage plan members generally get their services from a plan's network of providers.

Medicare Advantage plans cover all Medicare Part A and Part B services.

- In all types of Medicare Advantage Plans, members are always covered for emergency and urgent care.
- Medicare Advantage plans must cover all of the services that Original Medicare covers except hospice care and some care in qualifying clinical research studies.
- Original Medicare covers hospice care and some costs for clinical research studies, even for members enrolled in a Medicare Advantage plan.
- Medicare Advantage plans may offer extra coverage, like vision, hearing, dental, and other health and wellness programs.
- Most include Medicare prescription drug coverage (Part D).
- In addition to the Part B premium, members might pay a monthly premium for the Medicare Advantage plan.

General Provisions of Medicare Advantage Plans

Medicare Advantage Plans must follow Medicare's rules.

- Medicare pays a fixed amount for members' coverage each month to the companies offering Medicare Advantage plans.
- These companies must follow rules set by Medicare.
- Each Medicare Advantage plan can charge different out-of-pocket costs and have different rules for how its members get services (like whether they need a referral to see a specialist or if they have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care).
- These rules can change each year.
- The plan must notify its members about any changes before the start of the next enrollment year.

Different Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) plans

- In most HMOs, members can only go to doctors, other health care providers, or hospitals in the plan's network except in an urgent or emergency situation.
- Members may also need to get a referral from their primary care doctor for tests or to see other doctors or specialists.

Preferred Provider Organization (PPO) plans

- In a PPO, members pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network.
- Members usually pay more if they use doctors, hospitals, and providers outside of the network.

Private Fee-for-Service (PFFS) plans

- PFFS plans are similar to Original Medicare in that members can generally go to any doctor, other health care provider, or hospital as long as they accept the plan's payment terms.
- The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much members must pay when they get care.

Special Needs Plans (SNPs)

- SNPs provide focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, live in a nursing home, or have certain chronic medical conditions.

Different Types of Medicare Advantage Plans

HMO Point-of-Service (HMOPOS) plans

- These are HMO plans that may allow members to get some services out-of-network for a higher copayment or coinsurance.

Medical Savings Account (MSA) plans

- These plans combine a high-deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible).
- Members can use the money to pay for their health care services during the year.
- MSA plans don't offer Medicare drug coverage.
- If people want drug coverage, they have to join a Medicare Prescription Drug Plan.

Medicare Advantage Considerations

- Members have Medicare rights and protections, including the right to appeal.
- Members can check with the plan before they get a service to find out if it's covered and what the costs may be.
- Members must follow plan rules.
    - It's important for members to check with the plan for information about their rights and responsibilities.
- If members go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network, their services may not be covered, or their costs could be higher.
    - In most cases, this applies to Medicare Advantage HMOs and PPOs.
- Providers can join or leave a plan's provider network anytime during the year.
- The plan can also change the providers in the network anytime during the year.
- If members join a clinical research study, some costs may be covered by Original Medicare and some may be covered by their Medicare Advantage plan.
- Medicare Advantage plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage plans have a yearly limit on members' out-of-pocket costs for medical services.
    - Once members reach this limit, they will pay nothing for covered services.
    - This limit may be different between Medicare Advantage plans and can change each year.

Joining and Leaving a Medicare Advantage Plan

Medicare beneficiaries can join a Medicare Advantage plan even if they have a pre-existing condition, except for End-Stage Renal Disease (ESRD), for which there are special rules.

Beneficiaries can only join or leave a Medicare Advantage plan at certain times during the year.

- When Medicare beneficiaries first become eligible for Medicare, they can sign up during their Initial Enrollment Period.
- If they have Part A coverage and they get Part B for the first time during the General Enrollment Period, they can also join a Medicare Advantage Plan.
- Between October 15–December 7 anyone with Medicare can join, switch, or drop a Medicare Advantage Plan. The coverage will begin on January 1, as long as the plan gets the request by December 7.
- Between January 1–February 14, Medicare Advantage plan members, can leave their plan and switch to Original Medicare. If they switch to Original Medicare during this period, they will have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Coverage will begin the first day of the month after the plan gets the enrollment request.
- In most cases, members must stay enrolled for the calendar year starting the date their coverage begins. However, in certain situations, members may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period.
- 5-Star Special Enrollment Period - Members can switch to a Medicare Advantage Plan or Medicare Cost Plan that has 5 stars for its overall star rating from December 8-November 30. Member can only use this SEP once during the timeframe.

Prescription Drug Coverage with a Medicare Advantage Plan

- Medicare Advantage members usually get prescription drug coverage (Part D) through the Medicare Advantage plan.
- In certain types of Medicare Advantage Plans (PFFS or MSA plans) that don't offer drug coverage, members can join a Medicare Prescription Drug Plan.
- If a Medicare beneficiary's Medicare Advantage Plan includes prescription drug coverage and the Medicare Advantage plan member wants to join a Medicare Prescription Drug Plan, the member will be disenrolled from the Medicare Advantage plan and returned to Original Medicare.

Medicare Advantage Plan Costs

Members' out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium in addition to the monthly Part B premium.
- Whether the plan pays any of the monthly Part B premium.
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much members pay for each visit or service (copayments or coinsurance).
- The type of health care services a member needs and how often the member gets them.
- Whether members go to a doctor or supplier who accepts assignment (if they're in a Preferred Provider Organization, Private Fee-for-Service Plan, or Medical Savings Account Plan and the member goes out-of-network).
- Whether members follow the plan's rules, like using network providers.
- Whether members need extra benefits and if the plan charges for them.
- The plan's yearly limit on members' out-of-pocket costs for all medical services.
- Whether members have Medicaid or get help from their state.
- To learn more about costs in specific Medicare Advantage plans, visit Medicare.gov/find-a-plan.

General Provisions of Medicare Supplement Insurance (Medigap)

- Original Medicare pays for many, but not all, health care services and supplies.
- Medicare Supplement Insurance policies, sold by private companies, can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.
- Medicare Supplement Insurance policies are also called Medigap policies.
- Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S..
- If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then, your Medigap policy pays its share.
- You have to pay the premiums for a Medigap policy.
- Medigap policies are standardized.
    - Every Medigap policy must follow federal and state laws designed to protect members and they must be clearly identified as "Medicare Supplement Insurance."
    - Insurance companies can sell only a "standardized" policy identified in most states by letters A through D, F through G, and K through N.
    - Plans E, H, I, and J are no longer available to buy, but if people already have one of those policies, they can keep it.
    - All policies offer the same basic benefits, but some offer additional benefits so people can choose which one meets their needs.
        - In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

General Provisions of Medicare Supplement Insurance (Medigap)

Important Facts

- Some Medigap policies sold in the past cover prescription drugs, but Medigap policies sold after January 1, 2006 aren't allowed to include prescription drug coverage. If Medicare Supplement policyholders want prescription drug coverage, they can join a Medicare Prescription Drug Plan (Part D).
- Members must have Part A and Part B.
- Members pay the private insurance company a monthly premium for their Medigap policy in addition to their monthly Part B premium that they pay to Medicare.
- A Medigap policy only covers one person. Spouses must buy separate policies.
- It's important to compare Medigap policies since the costs can vary and may go up as people get older. Some states limit Medigap premium costs.

General Provisions of Medicare Supplement Insurance (Medigap)

When to Buy

- The best time to buy a Medigap policy is during the person's Medigap Open Enrollment Period.
    - This 6-month period begins on the first day of the month in which a person is 65 or older and enrolled in Part B. (Some states have additional Open Enrollment Periods.)
- After this enrollment period, people may not be able to buy a Medigap policy.
- If people are able to buy one, it may cost more.
- If people delay enrolling in Part B because they have group health coverage based on their (or their spouse's) current employment, their Medigap Open Enrollment Period won't start until they sign up for Part B.
- Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65.
    - If people are under 65, they might not be able to buy the Medigap policy they want, or any Medigap policy, until they turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65.

Overview of Medicaid

- Medicaid is a joint federal and state program that helps pay medical costs if you have limited income and resources and meet other requirements.
- Some people qualify for both Medicare and Medicaid and are called "dual eligibles."
- People who have Medicare and full Medicaid coverage have most of their health care costs covered.
    - They can get their Medicare coverage through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).
    - They can get Part D prescription drugs and Medicaid may still cover some drugs and other care that Medicare doesn't cover.
    - They may get coverage for services that Medicare may not or may partially cover, like nursing home care, personal care, and home- and community-based services.

Medicaid Qualifications

- Medicaid programs vary from state to state.
- They may have different names, like "Medical Assistance" or "Medi-Cal."
- Each state has different income and resource requirements.
- Many states have expanded their Medicaid programs to cover more people.
- Even if people were told they didn't qualify for Medicaid in the past, they may qualify under the new rules.
- In some states, people may need to be enrolled in Medicare, if eligible, to get Medicaid.

General Provisions of Prescription Drug Plans

Medicare offers prescription drug coverage to everyone with Medicare.

- If people decide not to join a Medicare drug plan when they are first eligible, and they don't have other creditable prescription drug coverage, and they don't get Extra Help, they will likely pay a late enrollment penalty if they join a plan later. Generally, they will pay this penalty for as long as they have Medicare prescription drug coverage.
- To get Medicare prescription drug coverage, Medicare beneficiaries must join a plan approved by Medicare to offer Medicare drug coverage. Each plan can vary in cost and specific drugs covered.
- There are 2 ways to get Medicare prescription drug coverage:
    - **Medicare Prescription Drug Plans** - These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) plans, and Medicare Medical Savings Account (MSA) plans. People must have Part A or Part B to join a Medicare Prescription Drug Plan.
    - **Medicare Advantage Plans (like HMOs or PPOs) or other Medicare health plans that offer Medicare prescription drug coverage** - Members will get all of their Part A, Part B, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."
- If people have employer or union coverage, they should call their benefits administrator before they make any changes, or before they sign up for any other coverage.
    - If you drop their employer or union coverage, they may not be able to get it back.
    - They also may not be able to drop their employer or union drug coverage without also dropping their employer or union health (doctor and hospital) coverage. If they drop coverage for themselves, they may also have to drop coverage for their spouses and dependents.

Joining and Leaving a Medicare Drug Plan

Beneficiaries can only join or leave a Medicare drug plan at certain times during the year.

- When Medicare beneficiaries first become eligible for Medicare, they can sign up during their Initial Enrollment Period.
- If they have Part A coverage and they get Part B for the first time during the General Enrollment Period, they can also join a Medicare drug plan.
- Between October 15–December 7 anyone with Medicare can join, switch, or drop a Medicare drug plan. The coverage will begin on January 1, as long as the plan gets the request by December 7.
- At any time if people qualify for Extra Help.
- In most cases, members must stay enrolled for the calendar year starting the date their coverage begins. However, in certain situations, members may be able to join, switch, or drop a Medicare drug plan during a Special Enrollment Period. Some examples include: moving out of the plan's service area, losing other creditable prescription drug coverage, live in an institution (like a nursing home), have Medicaid, qualify for Extra Help.
- 5-Star Special Enrollment Period - Members can switch to a Medicare drug plan that has 5 stars for its overall star rating from December 8-November 30. Member can only use this SEP once during the timeframe.

Medicare Drug Plan Costs

Actual drug plan costs vary depending on:

- Members' prescriptions and whether they are on the plan's formulary.
- The plan.
- Which pharmacy members use (whether the plan offers preferred or standard cost sharing, is out-of-network, or mail order).
- Whether the members get Extra Help paying their Part D costs.

Monthly Premium

- Most drug plans charge a monthly fee that varies by plan. Members pay this in addition to the Part B premium. If they're in a Medicare Advantage plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.
- If members have a higher income, they might pay more for their Part D coverage. If their income is above a certain limit, they will pay an extra amount in addition to their plan premium.

Yearly Deductible

- This is the amount members must pay before their drug plan begins to pay its share of their covered drugs. Some drug plans don't have a deductible.

Copayments or Coinsurance

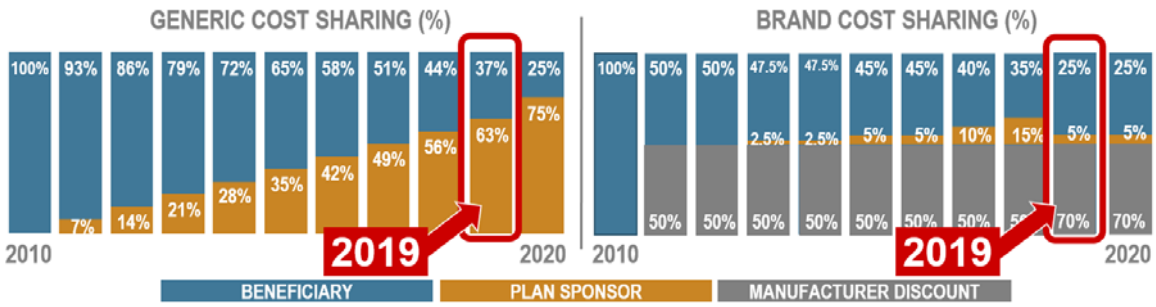
- These are the amounts members pay for their covered prescriptions after the deductible (if the plan has one). Members pay their share and the drug plan pays its share for covered drugs. These amounts may vary.

Medicare Drug Plan Costs - Coverage Gap

Coverage Gap

- Most Medicare drug plans have a coverage gap (also called the "donut hole").
- The coverage gap begins after members and their drug plan together have spent a certain amount for covered drugs.
- In 2019, once members enter the coverage gap, they pay 30% of the plan's cost for covered brand-name drugs and 37% of the plan's cost for covered generic drugs until members reach the end of the coverage gap.
- Not everyone will enter the coverage gap because their drug costs won't be high enough.
- These items all count toward you getting out of the coverage gap:
    - The yearly deductible, coinsurance, and copayments.
    - The discount members get on covered brand-name drugs in the coverage gap.
    - What members pay in the coverage gap.
- The drug plan premium and what you pay for drugs that aren't covered don't count toward getting you out of the coverage gap.
- Some plans offer additional cost sharing reductions in the gap beyond the standard benefits and discounts on brand-name and generic drugs, but they may charge a higher monthly premium.
- In addition to the discount on covered brand-name prescription drugs, there will be increasing coverage for brand-name and generic drugs in the coverage gap each year until the gap closes in 2020.

Coverage Gap Cost Sharing



On the path to a 25% cost share.

- Generic cost share will drop to 37% in 2019
- Brand cost share will drop to 25% in 2019

Medicare Drug Plan Costs - Catastrophic Coverage

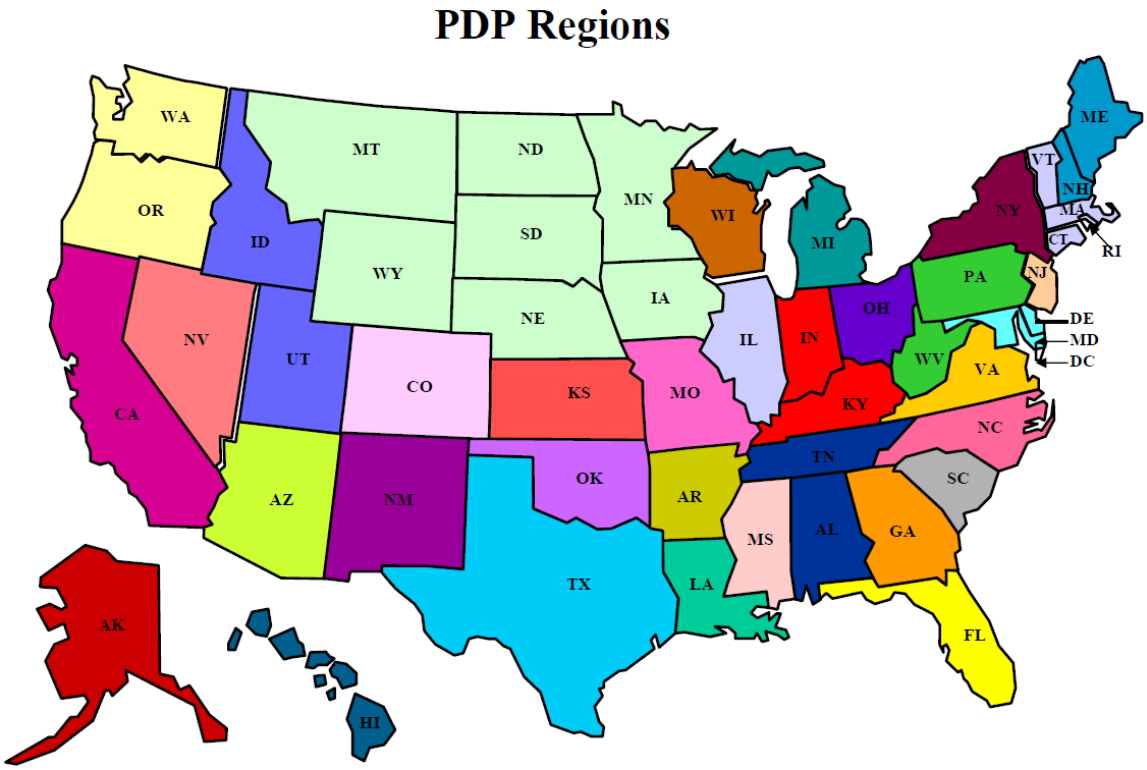
Catastrophic Coverage

- Once members get out of the coverage gap, they automatically get "catastrophic coverage."
- With catastrophic coverage, members only pay a coinsurance amount or copayment for covered drugs for the rest of the year.
- Note: If members get Extra Help, they won't have some of these costs.
- Usually, the amount members pay for a covered prescription is for a month's supply of a drug. However, members can request less than a month's supply for most types of drugs.
    - Some examples of when members might do this would be if they are trying a new medication that's known to have significant side effects or they want to synchronize the refills for all their medications.
    - In these cases, the amount members pay is reduced based on the day's supply they actually get.

Medicare Part D Service Areas

CMS has organized the 50 states into 34 PDP regions and 26 MA-PDs regions.

- It is important to note that an individual:
  - Is not allowed to enroll in more than one PDP at a time.
  - Is not allowed to enroll in both a PDP and MA-PD.
  - Is required to have their permanent physical residence address in the service area or region of the plan.



Note: Each territory is its own PDP region.

Medicare Part D Standard Benefit Parameters

Standard Benefit	2018	2019
Deductible	$405	$415
Initial Coverage Limit	$3,750	$3,820
Out-of-Pocket (OOP) Threshold	$5,000	$5,100
Total Covered Medicare Part D Drug Spend at OOP Threshold for Non-Applicable Beneficiaries	$7,508.75	$7,653.75
Full Subsidy, Full Benefit Dual Eligible Individuals (Over 100% of Federal Poverty Level - Category 1)		
Generic/Preferred Multi-Source Drug	$3.35	$3.40
Other	$8.35	$8.50

Source: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter

Determining True Out-of-Pocket Costs (TrOOP) and Total Drug Spend

Applies toward TrOOP

- Deductible if paid by beneficiary or qualified third party (such as SPAPs)
- Co-payments or co-insurance made by the beneficiary
- Co-payments or co-insurance made by a qualified third party (such as SPAPs) on behalf of the beneficiary
- Low income subsidy amounts
- Money spent out of pocket while in the Coverage Gap if paid by beneficiary or qualified third party (such as SPAPs)

Does not apply toward TrOOP

- Premium payments
- Payments made by group health plans, insurers, government funded health programs, or similar third parties (except for SPAPs)
- Money spent on drugs not covered by Medicare Part D (excluded drugs)

Formulary and Formulary Requirements

- The drugs covered by each plan vary, so there is no single drug list that applies to all plans. All Medicare drug plans must make sure that the people in their plan can get medically-necessary drugs to treat their conditions.
- Medicare drug plans cover generic and brand-name drugs but they do not cover OTC drugs except as part of step therapy protocol where enrollee does not pay for the drug.
- There are certain drugs that Medicare drug plans may not cover as part of the standard benefit, such as benzodiazepines, barbiturates, drugs for weight loss or gain, and drugs for erectile dysfunction. Some plans may choose to cover these drugs as an added benefit. Plans may only cover “Part D drugs” as defined, unless they offer an enhanced benefit, in which case, they may cover certain excluded drugs. For example, a Part D drug must be a prescribed drug, purchased in US, not covered under Part B.
- All Medicare drug plans generally must cover at least two drugs in each category of drugs, but plans can choose which specific drugs are covered in each category. Plans are required to cover almost all drugs in six classes: anti-psychotics, anti-depressants, anti-convulsants, immunosuppressants, cancer, and HIV/AIDS drugs.
- Each month that members fill a prescription, their drug plan mails them an "Explanation of Benefits" (EOB) notice. This notice gives the member a summary of their prescription drug claims and their costs.

Part D Excluded Drugs

Certain drugs, classes of drugs, or their medical uses are excluded by law from Part D coverage.

- Some of these excluded drugs and drug uses include:
  - Non-prescription drugs.
  - Prescription vitamins and minerals (except prenatal vitamins and fluoride preparation).
  - Benzodiazepines and Barbiturates.
  - Sexual and Erectile Dysfunction drugs (except when used for other FDA approved use such as pulmonary hypertension).
- Any amount that a beneficiary spends on excluded drugs does not count towards TrOOP when these drugs are covered as part of an enhanced plan.

Cost-Sharing Tiers

- To have lower costs, many plans place drugs into different “tiers” on their drug lists (or formularies).
- The cost sharing for each tier is different.
- Each plan can divide its tiers in different ways.
- A drug in a lower tier will have lower cost sharing than a drug in a higher tier.
- A plan’s drug list might not include all drugs a member takes. However, in most cases, a similar drug that is safe and effective will be available.

Important Drug Coverage Rules

Plans may utilize several coverage rules for drugs on its formulary:

Prior authorization

- Members and/or their prescribers (doctors or other health care providers who are legally allowed to write prescriptions) must contact the drug plan before a member can fill certain prescriptions.
- The prescribers may need to show that the drug is medically necessary for the plan to cover it.

Quantity limits

- Limits on how much medication a member can get at a time or a year.

Step therapy

- Members must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

The plan formularies and drug coverage and pricing tools indicate whether or not a particular medication has a prior authorization, a quantity limit or step therapy.

- If the members and/or their prescribers believe that one of these coverage rules should be waived, members can ask for an exception.

Temporary Supply and Transition Fill Process

- Transition fill is the temporary supply of Part D-covered drug that is non-formulary, or on formulary with a prior authorization, step therapy, quantity limits (quantity vs. time; daily does less than FDA maximum labeled dose limits), or age edits per formulary utilization management edits.
- Transition fill is not allowed for Non Part D covered drugs (not covered under Part D benefit) or Part B vs. Part D drugs or Part B only drugs.
- Serves to ensure access to medications and continuity of care for eligible Part D members.

TF Condition	Description	Allowed TF Days Supply
Newly Enrolled in Plan	Includes, not necessarily limited to: • New following AEP or SEP • Newly eligible Medicare beneficiary from other coverage • Switching from one plan to another after start of contract year – even under same contract ID	• Retail: 30 cumulative days within first 90 days in new plan (or defaults to plan setup) • LTC and/or LICS III: 34 days per fill (less as written) cumulative to minimum 91 days and maximum 102 days / first 90 days (or defaults to plan setup) • LTC: 14 days per fill (less as written) oral solid brands cumulative to maximum 102 days
Renewing Member – across plan contract / calendar years	• Renewing member and across calendar year – has utilization history of impacted drug within 180 days from claim date and previous claim either not TF or TF for different reason (ex: prior year TF was for reason PA; current yr TF for reason non-formulary) • When member not transition before start of new plan benefit year	• Retail: 30 cumulative days within first 90 days of calendar year (or defaults to plan setup) • LTC and/or LICS III: 34 days per fill (less as written) with multiple refills to minimum 91 days and maximum 102 days / first 90 days (or defaults to plan setup) • LTC: 14 days per fill (less as written) oral solid brands cumulative to maximum 102 days

Beneficiary Rights

Medicare beneficiaries have certain guaranteed rights and protections, regardless of the type of plan.

These rights include:

- Being treated with dignity and respect at all times.
- Being protected from discrimination.
- Getting information about Medicare that is easy to understand and helps to make health care decisions.
- Getting answers to questions about Medicare.
- Receiving culturally competent services.
- Making complaints, also known as grievances, about payment, services, or other problems, including quality of care.
- Appealing decisions related to receipt of or payment for services or benefits.
- Having personal health information kept private.
- Fair, efficient and timely appeals process.
- Fast track appeals process (in certain situations).

Coverage Determinations

- If a pharmacist tells a member that a Medicare drug plan won't cover a drug that the member thinks should be covered, or it will cover the drug at a higher cost than the member thinks is appropriate, the member has the right to request that the plan cover the drug or cover it at the lower cost. This request is called a request for a coverage determination.
- For some types of coverage determinations called exceptions (when the member is requesting coverage for a non-formulary drug or a formulary drug at a lower tier cost sharing), the member will need a supporting statement from a prescriber explaining why the member needs the drug being requested and why the formulary alternative is not suitable. An exception may also be requested if the member believes that he/she should not have to meet the utilization review criteria (such as prior authorization or step therapy) applicable to certain formulary drugs.

Appeals and Grievances

- If a member asks for a coverage determination and the member disagrees with the plan's decision, the member can appeal the decision.
- An explanation of the appeal process is provided to the member in writing via the plan's Summary of Benefits and Evidence of Coverage documents. Members also receive an explanation of their appeal rights when a coverage determination request is denied or a claim rejects at the pharmacy.
- If the member has a complaint about any aspect of the plan other than coverage or payment for a drug, the member has the right to file a complaint with the plan (called a grievance).

Extra Help for People with Limited Income

- Medicare beneficiaries may be eligible for “Extra Help” if they have limited income and resources. This program is known as Low Income Subsidy (LIS).
- The amount of extra help they receive is based on their income and resources.
- If a member qualifies for Extra Help and joins a Medicare drug plan, the member may get help paying the monthly premium, the annual deductible, and the prescription copays/co-insurance.
- Once a beneficiary qualifies for LIS, he/she is eligible for the subsidy until the end of the year. CMS will let enrollees know when they lose LIS status, but for those that are not deemed (i.e. automatically qualified to receive the subsidy), they have to apply.
- CMS will re ‘deem’ or re-qualify a beneficiary for LIS every year.

Extra Help for People with Limited Income

- Beneficiaries automatically qualify for Extra Help if they have Medicare and meet one of these conditions:
  - They have full Medicaid coverage.
  - They get help from their state Medicaid program paying their Part B premiums (belong to a Medicare Savings Program).
  - They get Supplemental Security Income (SSI) benefits.
- If they didn't automatically qualify for Extra Help, they can apply:
  - Call Social Security at 1-800-772-1213 to apply by phone or to get a paper application. TTY users should call 1-877-486-2048.
  - Visit www.socialsecurity.gov to apply online.
  - Apply at their State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE, and say "Medicaid" to get the telephone number, or visit www.medicare.gov.
- Note: a beneficiary can apply for Extra Help at any time.

Low Income Subsidy (LIS) Benefits

LIS Benefits fall into 2 categories:

- **Full Subsidy Benefits:** Beneficiaries who qualify for full subsidy have the following benefit:
  - No premium payment up to the regional benchmark amount (each year the government establishes the maximum it will pay for monthly premiums on behalf of members, this maximum is called the benchmark).
  - No deductible.
  - No coverage gap.
  - No or nominal co-pays until the beneficiary hits the catastrophic coverage level.
  - No cost sharing in the catastrophic level.
- **Partial Subsidy Benefits:** Beneficiaries who qualify for partial subsidy are entitled to the following:
  - Sliding scale premium assistance (based on income level).
  - Reduced deductible.
  - No coverage gap.

Reduced co-insurance until the beneficiary hits the coverage gap at which time beneficiaries pay reduced co-insurance in the coverage gap and nominal cost sharing in the catastrophic level.

Summary

CMS provided PDP sponsors with guidelines to use in developing their curricula for training and testing agents and brokers for the upcoming plan year. 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 overview of Medicare Basics and Beneficiary Protections. Other courses address Enrollment, Marketing Guidance, and Product-Specific details.

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