MedicareBlue℠ Rx (PDP)

Agent Administrative Guide

2017

For Agent use only.
Not for use with the general public.

MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

RAS1077R09

Introduction: Using this Guide for Training & Certification

Introduction

Every individual or entity engaged in Medicare business must comply with all applicable federal and state regulatory requirements, laws and rules that apply to Medicare products.

Compliance with the Centers for Medicare & Medicaid Services (CMS) regulatory guidance and requirements, including Medicare product training, is important because:

- It protects Medicare beneficiaries from marketing and sales activities that may mislead, confuse or misinform them
- It protects sales persons from being induced or encouraged to practice marketing and sales activities that may mislead, confuse or misinform beneficiaries
- It protects Plan Sponsors and sales persons from sanctions and punishments such as contract termination
- **It is required by CMS**

How to Use this Guide

The information provided in this guide offers a basic understanding of information you need to become certified and to service, market and sell Medicare Part D products from this Plan Sponsor. To see the CMS guidance/requirements supporting the information in this guide, please refer to the Medicare Marketing Guidelines or the applicable chapter of the Prescription Drug Benefit Manual. This guide is meant to be a reference for your training and to help answer questions you may be asked later.

Use this guide as a resource as you complete the online training. Only by successfully completing each module assessment online will you complete the training and be certified to sell Medicare products.

Contact your local plan for any specific questions that you may have related to the content of this guide.

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Important Phone Numbers and Addresses

Agent/Broker Service Lines & Addresses	
DialogDirect (formerly Novo1)	
MedicareBlue Rx pre-enrollment	**1-866-464-3919**
Hours of operation 10/1-2/14	8 a.m. to 8 p.m., daily, Central and Mountain Times; recording after hours
Hours of operation 2/15-9/30	8 a.m. to 8 p.m., Monday through Friday, Central and Mountain Times; recording at other times
TMG	
MedicareBlue Rx agent post-enrollment	**1-866-849-2498**
MedicareBlue Rx application fax number	**1-855-874-4702**
Hours of operation	8 a.m. to 6 p.m., Monday through Friday, Central and Mountain Times; recording at other times
MedicareBlue Rx overnight address	TMG Health, Inc. 25 Lakeview Drive Jessup, PA 18434

Individual Pre-enrollment (DialogDirect)	
MedicareBlue Rx Customer Service	**1-866-434-2037**
TTY	**711**
Customer Service address	MedicareBlue Rx Customer Service 4301 Cambridge Road Fort Worth, TX 76155
Hours of operation 10/1-2/14	8 a.m. to 8 p.m., daily, Central and Mountain Times; recording at other times
Hours of operation 2/15-9/30	8 a.m. to 8 p.m., Monday through Friday, Central and Mountain Times; recording at other times
Days closed	10/1-2/14: CMS-approved holidays (typically Thanksgiving Day and Christmas Day); 2/15-9/30: Federally recognized holidays
Pre-enrollment website	**YourMedicareSolutions.com**
Individual Post-enrollment	
TMG	
MedicareBlue Rx Customer Service	**1-888-832-0075**
MedicareBlue Rx Customer Service TTY	**711**
MedicareBlue Rx Customer Service address	P.O. Box 3178 Scranton, PA 18505-9971
MedicareBlue Rx Customer Service fax number for enrollments, disenrollments and plan changes	**1-855-874-4702**
MedicareBlue Rx Customer Service fax number for privacy issues, appeals and all other matters	**1-855-874-4705**
Hours of operation 10/1-2/14	8 a.m. to 8 p.m., daily, Central and Mountain Times; recording at other times
Hours of operation 2/15-9/30	8 a.m. to 8 p.m., Monday through Friday, Central and Mountain Times; recording at other times
Days closed	10/1-2/14: CMS-approved holidays (typically Thanksgiving Day and Christmas Day); 2/15-9/30: Federally recognized holidays

Medicare	
Main number	**1-800-MEDICARE (1-800-633-4227)**
TTY	**1-877-486-2048**
Website	**Medicare.gov**
Hours of operation	24 hours a day, seven days a week
Report Suspected Fraud or Abuse	
Report any issues or concerns to:	**MedicareBlue Rx at 1-866-311-4216**
	Your local Plan Sponsor contact
	1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week
	Health and Human Services Office of Inspector General Hotline at 1-800-447-8477
Social Security	
Main number	**1-800-772-1213**
TTY	**1-800-325-0778**
Website	**ssa.gov** or **socialsecurity.gov** (both go to the same site)
Hours of operation	7 a.m. to 7 p.m. Monday through Friday (no time zone is given)

1. Eligibility and Enrollment Periods

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Introduction

This section provides information about beneficiary eligibility and CMS-designated enrollment periods for Original Medicare, Medicare Advantage and Medicare Prescription Drug (Part D) plans. Some enrollment periods are the same for both Medicare Advantage and Prescription Drug Plans, while others apply to only one product, but may affect the other. Basic eligibility and enrollment information is also described for Medigap and Medicare Cost plans.

Generally, once beneficiaries elect a Medicare Part D or Medicare Advantage plan, they are "locked in" to that coverage for the remainder of the plan year. (A plan year is usually a calendar year.) This "lock-in" also creates circumstances in which beneficiaries may be "locked out" of other plans until the next valid enrollment period.

The Medicare Advantage Disenrollment Period allows beneficiaries to disenroll from a Medicare Advantage plan between January 1 and February 14 each year.

Learning Objectives

At the end of this section you will be able to:

- Identify the CMS Medicare Managed Care Manual and Prescription Drug Benefit Manual Guidance that defines eligibility guidelines and enrollment periods
- Identify whether a beneficiary is eligible for Original Medicare, a Part D, MA or MA-PD plan
- Identify valid enrollment periods for eligible beneficiaries

Medicare Coverage

Medicare is separated into four parts:

- Part A, Hospital Insurance (Original Medicare)
- Part B, Medical Insurance (Original Medicare)
- Part C, Medicare Advantage Program (established in the 1997 Balanced Budget Act as Medicare + Choice and reformed under the Medicare Modernization Act (MMA) in 2003)
- Part D, Prescription Drug Program (part of the 2003 MMA reforms and effective January 1, 2006)

Original Medicare Eligibility

To receive Medicare benefits, an individual must:

- Be a U.S. citizen,

or

- Have a resident visa and have lived in the U.S. for five consecutive years,

and

- Meet the age or disability qualifications and requirements outlined for eligibility for Medicare programs.

Who's Eligible for Part A?

Age 65 remains the starting date for Medicare eligibility, although the retirement age for full Social Security benefits is increasing. An individual can get Medicare Part A at age 65 without paying a premium if:

- The individual or spouse has had Medicare taxes deducted from salaries or wages for at least 40 quarters (10 years), or
- The individual is already receiving retirement benefits from Social Security or the Railroad Retirement Board, or
- The individual is eligible to receive Social Security or Railroad benefits but has not yet filed for them, or
- The individual or spouse had Medicare-covered government employment

An individual under age 65 can get Part A without paying a premium if:

- The individual has received Social Security Disability Insurance (SSDI) or Railroad Retirement Board disability benefits for 24 months, or
- The individual has end-stage renal disease (ESRD) and is a kidney dialysis or kidney transplant patient, regardless of age

Individuals who have not paid into Medicare for the required 40 quarters may purchase Part A by paying a monthly premium. The amount of the premium depends on the number of quarters that Medicare taxes were paid. People with limited income or resources may be eligible for Part A premium payment help from their state.

When to Enroll in Part A

Enrollment in Part A is designed to be automatic for individuals who have applied for Social Security benefits, and coverage begins the first day of the month in which the individual turns age 65. Eligible individuals with a birthday that falls on the first of the month will be enrolled in Part A on the first of the month prior to their 65th birthday month. A Medicare card should arrive two to three months prior to that date. If the beneficiary does not receive a card, he or she must contact Social Security to enroll in Medicare Part A and, if desired, Part B.

People born between 1943 (age 65 in 2008) and 1954 are not eligible to collect their full Social Security benefit until they turn 66 although Medicare benefits are available to eligible beneficiaries at age 65 regardless of whether they begin collecting Social Security benefits. Enrollment will not be automatic if the individual is not collecting Social Security benefits at age 65. In this instance, the individual must call his or her local Social Security office to obtain Medicare enrollment materials.

Who's Eligible for Part B?

Individuals are eligible for Part B coverage if they:

- Are age 65 or older and entitled to Part A
- Are disabled and have received 24 months of Social Security Disability Insurance (SSDI)
- Have end-stage renal disease (ESRD), regardless of age

- Part A and Part B premium costs are subject to change each year
- Call 1-800-MEDICARE or visit Medicare.gov for updated information

When to Enroll in Part B

Enrollment in Part B is voluntary and requires paying a monthly premium. In 2016, the standard monthly premium is $121.80. This premium may change for 2017. Anyone who is entitled to Part A is also eligible for Part B, and Part B is often discussed at the time the beneficiary enrolls in Part A.

Beginning in 2007, Part B premiums began to be indexed based on income so that people with higher incomes pay higher premiums. In 2016, the Part B premiums based on income (not including any applicable late enrollment penalties) are:

Beneficiaries Whose Income when Filing a:		**In 2016 Beneficiary Pays***
Individual Tax Return Is…	**Joint Tax Return Is…**	
Less than or equal to $85,000	Less than or equal to $170,000	$121.80
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$170.50
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$243.60
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$316.70
Greater than $214,000	Greater than $428,000	$389.80

*These numbers reflect 2016 amounts and may change for 2017.

Medicare Part B has three enrollment periods during which eligible individuals may choose to enroll:

- **Initial Enrollment Period** (IEP): For most individuals this is the seven-month period that begins three months before the month in which the person turns age 65, includes the month he or she turns age 65, and continues for three months after turning age 65. If the beneficiary elected Social Security benefits in the month(s) preceding their IEP, he or she will automatically be enrolled in Part A and Part B (and will have the opportunity to decline Part B). Those who have **not** elected Social Security benefits will need to apply with the Social Security Administration during their IEP.

- **Special Enrollment Period** (SEP): If an individual does not enroll in Part B when first eligible because of having group health coverage from his or her employer or a spouse's employer (based on full-time active employment), then the individual may enroll at one of these times, whichever is first:
    - Anytime they are still covered by group health coverage available through current employment
    - Eight months following the month the group health coverage ends
    - When the employment ends

  Individuals who enroll in Part B during this SEP do not pay a penalty for the Part B premium. If an individual continues group health coverage through COBRA after employment ends, their Part B SEP begins when employment ends, not when COBRA ends. If the individual enrolls when COBRA ends, a penalty may apply.

- **General Enrollment Period**: The General Enrollment Period runs from January 1 through March 31 each year, with coverage taking effect the following July 1. Individuals who did not enroll in Medicare Part B during their IEP or SEP, or dropped Part B (for reasons other than full-time employment providing group benefits) and want to re-enroll, can sign up during this time. Individuals signing up during the General Enrollment Period will be subject to a penalty charge. Typically, the cost of the Medicare Part B premium will go up 10% for each full 12-month period that the individual was eligible but did not enroll. This penalty is assessed by the Social Security Administration.

Since Part B coverage is voluntary, newly-eligible individuals need to evaluate their options. Eligible individuals who are enrolling in Part A typically enroll in Part B at the same time. Individuals eligible for employer or union group health benefits through full-time employment or as a dependent of a spouse who is working full time may prefer to delay enrollment. Part B coverage is not retroactive – it begins based on the enrollment period during which the individual enrolls. Even though there is a premium for Part B coverage, individuals not enrolled in employer/union group benefits should be encouraged to join during their IEP because:

- Out-of-pocket costs for medical care are lower with Part B than without
- Individuals must have Part B in order to enroll in a Medicare Advantage plan (Part C) or purchase a Medigap product (also known as Medicare Supplement) or Medicare Cost product
- They can only enroll during a general open enrollment period after their IEP, and may pay a penalty for late enrollment in the form of higher monthly premiums for the rest of their life
- Both Parts A and B are required for Medicare to cover certain dialysis treatment and kidney transplant services

CMS Enrollment and Disenrollment Guidance for Medicare Advantage and Part D

CMS provides Plan Sponsors guidance for eligibility and enrollment into or disenrollment from Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) Plans and Medicare Part D in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual.

Basic Eligibility Guidelines for Medicare Advantage and Part D

All Medicare beneficiaries are eligible to apply for a Medicare PDP, MA or MA-PD plan. Each type of plan has specific eligibility requirements a Medicare beneficiary must meet in order to enroll.

MA/MA-PD Eligibility

Medicare beneficiaries can apply for an MA or MA-PD if they:

- **Have both Medicare Part A and Part B.** Most beneficiaries do not pay premiums for Part A. However individuals who did not work enough quarters to qualify for Part A with no premium may enroll in and pay premiums for Part A benefits. Beneficiaries also pay premiums for Part B. To enroll in an MA or MA-PD plan, beneficiaries must continue to pay their Part B premium (and Part A if applicable) if not otherwise paid for by Medicare or another third party.
- Reside in the plan's service area.
- Do not have end-stage renal disease (ESRD), unless they are currently a member of other coverage offered by the plan when they apply and the disease is being covered by their current plan OR they have had a successful kidney transplant and/or no longer need dialysis.
- Enroll during a valid enrollment period.

PDP Eligibility

Medicare beneficiaries can apply for a PDP if they:

- Have Medicare Part A **and/or** Part B. Beneficiaries not enrolling in Part B for any reason should still consider enrolling in a PDP when they are first eligible to avoid late enrollment penalties.
- Reside in the plan's service area.
- Enroll during a valid enrollment period.

In 2011, Medicare Part D enrollees began paying income-related premium adjustment amounts to Medicare, called the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). Social Security determines which beneficiaries have to pay the higher amounts and notifies affected members. The income-related amounts Part D members will pay are in the chart on the next page. This amount is in addition to any late enrollment penalty that may apply.

Beneficiaries whose income when filing a:		**Pay this additional income-related amount in 2017*…**
Individual Tax Return Is…	**Joint Tax Return Is…**	
Less than or equal to $85,000	Less than or equal to $170,000	$0
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$12.70
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$32.80
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$52.80
Greater than $214,000	Greater than $428,000	$72.90

*Note: These numbers reflect 2017 amounts and may change for 2018.

Enrollment Periods

In order for a Plan Sponsor to accept a request for enrollment or disenrollment, it must be made during a valid enrollment period. CMS identifies several enrollment periods that are described below. It is up to the Plan Sponsor to verify that requests for enrollment or disenrollment are valid based on the enrollment period.

Annual Enrollment Period (AEP)

The AEP occurs from October 15 through December 7 each year. During this time, all Medicare-eligible beneficiaries can enroll in, disenroll from or change MA, MA-PD or PDP plans.

Coverage changes made during the AEP are effective January 1 of the following year. If Medicare-eligible beneficiaries do not make a change, their current coverage continues into the next year with any applicable premium or benefit design adjustments.

Beneficiaries can make multiple enrollment elections during this period. However, the last enrollment or disenrollment choice made during this enrollment period, as determined by the application date, will be the choice that becomes effective January 1. The application date is the date the enrollment request is received by the plan. **Remember that receipt by a sales person is considered receipt by the plan.**

Medicare Advantage Disenrollment Period (MADP)

The Medicare Advantage Disenrollment Period (MADP) occurs every year from January 1 through February 14. During this time, all Medicare-eligible beneficiaries can disenroll from an MA or MA-PD plan and return to Original Medicare. They can also enroll in a stand-alone prescription drug plan at that time, regardless of whether the plan from which they are disenrolling includes drug coverage.

The effective date of the new coverage will be the first of the month following the application date.

The **application date** is the date the enrollment request is received by the plan. This includes the date it is received by a sales person.

<table>
<tr><th colspan="3">2016</th><th colspan="3">2017</th></tr>
<tr><th>October</th><th>November</th><th>December</th><th>January</th><th>February</th><th>March</th></tr>
<tr><td>1</td><td></td><td>31</td><td>1</td><td></td><td>31</td></tr>
<tr><td>Marketing of 2017 plans begins</td><td colspan="2">AEP
Enrollment forms may be signed and submitted from October 15 – December 7</td><td colspan="2">MADP
Prescription drug plan enrollments can be submitted from January 1 – February 14 by beneficiaries who disenroll from MA or MA-PD plans</td><td></td></tr>
<tr><td>Certification must be completed before marketing begins</td><td colspan="2">SEP
2017 enrollment forms may be signed and submitted beginning October 1</td><td>AEP elections become effective January 1</td><td colspan="2">MADP
Enrollments will be effective the 1st of the month following the application date</td></tr>
</table>

Initial Enrollment Period (IEP) & Initial Coverage Election Period (ICEP)

Newly-eligible beneficiaries have two enrollment periods that often coincide: the Initial Enrollment Period (IEP) and the Initial Coverage Election Period (ICEP). The difference is that the IEP is the individual's initial eligibility for Part D while the ICEP is an individual's initial eligibility for MA plans. Both enrollment periods generally last seven months – beginning three months before the individual's 65th birthday month, including the birthday month, and ending three months after the birthday month.

Remember that the initial enrollment period for Original Medicare occurs for most people at age 65. It may be later if the person continues to work beyond age 65 or earlier if the person is disabled or diagnosed with ESRD. Enrollment is usually automatic if the individual has already applied for or is receiving Social Security benefits. However, those born between 1943 and 1954 are not eligible to collect their full Social Security benefit until age 66 and will need to apply for Medicare if they do not choose to start receiving Social Security payments by age 65.

The IEP for Part D is triggered by the beneficiary's entitlement to Part A benefits, regardless of whether the beneficiary enrolls in Part B at the same time. The beneficiary does not need to elect both Part A and Part B to be eligible for Part D benefits. However, delaying enrollment in Part B does impact the ICEP by reducing the enrollment period timeframe.

The enrollment periods for prescription drug and MA plans often happen simultaneously. For beneficiaries, this means that during their IEP they may make one Part D election, including enrollment into an MA-PD plan if they enroll in both Part A and Part B. During their ICEP, beneficiaries may also make one MA election, including enrollment into an MA-PD plan. If the beneficiary elects an MA-PD plan, they have used both their IEP for prescription drug coverage and their ICEP for MA plan coverage.

If enrollment into Part B is postponed, beneficiaries should still consider enrolling in Part D, particularly if they do not have creditable prescription drug coverage. If beneficiaries do not enroll for Part D when first eligible and they do not have creditable prescription drug coverage, they face paying a late enrollment penalty (LEP) when they enroll at a later date. Information about creditable prescription drug coverage and the late enrollment penalty can be found in *Section 5*.

Example 1: IEP for Part D surrounding 65th birthday:

Mrs. Smith's 65th birthday is on April 20, 2010. She is eligible for Medicare Part A and her Part B initial enrollment period begins on January 1, 2010. Therefore, her IEP for Part D begins on January 1, 2010, and ends on July 31, 2010.

Example 2: IEP for working individual:

Mr. Hackerman's 65th birthday is March 23, 2010. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2010, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2009 – June 2010. Hence, his IEP for Part D is also December 2009 – June 2010.

Note: Not all employers require age 65 or older employees to enroll in Medicare. Individuals who continue working past age 65 should check with their employer to see what is required.

March	April	May	June	July	August	September
			15			**1**
			65th Birthday			
			Initial Coverage Election Period (ICEP) for **MA** occurs during the 3 months before enrolling in both Part A AND Part B due to postponement of Part B			Quit working and enrolled in Part B

Beneficiaries under age 65 who qualify for Original Medicare are also eligible to enroll in Part D or MA plans, although the timeframes for enrolling may differ based on their individual circumstances. Sales persons and/or beneficiaries should contact Medicare for additional information in these situations.

Beneficiaries entitled to Original Medicare before age 65 receive a second IEP for Part D when they reach age 65.

IEP/ICEP Effective Dates

The **application date** is the date the enrollment request is received by the plan. This includes the date it is received by a sales person.

The effective date of coverage for IEP/ICEP enrollments is based on the application date, and whether it is before or after the month a beneficiary becomes entitled to Medicare:

- Beneficiaries who submit applications during the three months ***before*** they are entitled to Medicare have an effective date of coverage of the first day of the month in which they are entitled to Original Medicare. Using the example of Julia who turns 65 in June, if her application date is March 15, her effective date of coverage is June 1, the first day of the month in which she is entitled to Medicare.
- Beneficiaries with an application date ***during*** the month of entitlement, or in the three months ***following*** the month of entitlement to Medicare, will have an effective date of coverage of the first of the month following the month of the application date. If Julia's application date is July 15, her effective date of coverage is August 1.

March	April	May	June	July	August	September
			12			
			65th Birthday			
Initial Enrollment Period (Part D) & Initial Coverage Election Period (MA)						
Enrollment form received during 3 months prior means June 1 effective date			Enrollment form received during last 4 months means effective date is the first of the month following application date			

Special Enrollment Periods (SEPs)

Special enrollment periods occur for a limited amount of time and are offered due to unique circumstances defined by CMS. SEPs may apply to either or both Part D and MA enrollments and disenrollments. However, the reason for the SEP determines the particular election option(s) available to the individual.

The SEP ends once an election is made, or when the time frame for that SEP expires, whichever occurs first. The effective date of coverage depends on the individual SEP and the circumstances that caused the SEP. Some of the most common reasons for a SEP include:

- Permanent change in residence (move) into or out of a service area (including release from incarceration)
- Enrolling in or leaving employer/union group health coverage (unless the loss of coverage was due to non-payment of premiums)
- Qualifying or no longer qualifying for low income subsidy (LIS)
- Qualifying as "dual-eligible" (eligible for both Medicare and Medicaid)
- Moving into or out of a long-term care facility, such as a nursing home
- A Plan Sponsor decides not to renew a contract or a Plan Sponsor's contract is terminated by CMS
- Involuntarily losing creditable prescription drug coverage
- Leaving a PACE program
- Belonging to a state pharmacy assistance program (SPAP)
- Moving back to the U.S. after permanently living outside the U.S.
- Wanting to enroll in a plan with a 5-Star Rating

Since 2012, there has been a SEP that will allow individuals to enroll in a 5-Star Medicare Advantage or Part D plan anytime during the year (except for a one-week period of time from December 1 through December 7). The change will be effective the first of the following month.

Individuals may also qualify for a SEP due to product misrepresentation by a sales person or plan/Part D sponsor. This type of SEP can only be granted by CMS when the beneficiary contacts CMS with this concern.

In addition to more information on situations qualifying for SEPs, CMS also identifies numerous SEPs that qualify for "Exceptional Conditions" as described in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the PDP Guidance. Some common SEPs for Exceptional Conditions include:

- The **SEP Employer Group Health Plans (EGHP)** which allows enrollment into or disenrollment from MA and/or PDP plans when the beneficiary has an opportunity to enroll in or disenroll from an employer/union group health plan.

- The **SEP for Individuals Who Dropped a Medigap Policy When They Enrolled for the First Time in an MA Plan and Who Are Still in a "Trial Period"** allows Medigap members who leave their Medigap plan to try an MA plan for the first time to disenroll from the MA plan and return to their Medigap plan within the first 12 months they are a member of the MA plan. The MA disenrollment allows the member a guaranteed issue

opportunity to return to a Medigap policy without medical underwriting. Individual state laws determine what Medigap policies are available.

- **Part D Coordinating SEPs** apply in situations when enrollment into or disenrollment from an MA or PDP plan creates a SEP for the other type of plan.

- **SEP for Beneficiaries Age 65 (SEP65)** allows a newly eligible beneficiary who enrolls in Part A and Part B and elects a Medicare Advantage plan at age 65 the opportunity to disenroll from the MA plan within a 12-month period, and be guaranteed the right to purchase a Medigap policy without medical underwriting.

- **SEP for Non-U.S. Citizens Who Become Lawfully Present** allows non-U.S. citizens who become lawfully present in the United States an opportunity to request enrollment in any PDP for which he or she is eligible, including an MA-PD. This SEP begins the month the lawful presence starts and ends when the individual makes an enrollment request, or two full calendar months after the month it begins, whichever occurs first.

For additional information on SEPs:

- Review the Medicare Managed Care Manual, Chapter 2 – Enrollment and Disenrollment
- Review the Medicare Prescription Drug Benefit Manual, Chapter 3 – Eligibility, Enrollment and Disenrollment
- Contact the Broker Help Desk
- Contact the Plan Sponsor

Because it's possible that more than one enrollment period may apply when a beneficiary is enrolling, the following questions may help sales persons determine the valid enrollment period and possible effective date:

1. Is the beneficiary newly eligible for Medicare?
2. What are the beneficiary's Part A and Part B effective dates?
3. Does the beneficiary have a situation that may allow for a Special Enrollment Period (SEP)?
4. Is the beneficiary applying during the Annual Enrollment Period (AEP)?

Beneficiaries are eligible for Part D coverage if they are entitled to Part A and/or enrolled in Part B of Original Medicare, so you must also consider which product they wish to enroll in. CMS enrollment guidance includes a hierarchy that is used to determine the effective date of coverage when a beneficiary is eligible for more than one enrollment period.

Other Programs and Supplements

To help beneficiaries manage the out-of-pocket health care costs that Original Medicare leaves behind, and provide more choices and benefits, additional programs and supplements are available:

- Medigap plans, such as Medicare Supplements or Select plans
- Medicare Cost plans

Medigap Plans

Individuals with Original Medicare (both Parts A and B) may purchase a Medigap policy – also known as Medicare supplement insurance – from private insurance companies or organizations. Medigap insurance pays Medicare's deductibles and/or coinsurance/copays and may also offer coverage for services not covered by Original Medicare. Medigap plans coordinate with Original Medicare as secondary insurance coverage.

Who's Eligible for a Medigap Plan?

Individuals are eligible for a Medigap plan if they:

- Are a permanent resident of the state in which the plan is offered
- Are enrolled in Medicare Part A and Medicare Part B
- Continue to pay the Part B premium

When to Enroll in a Medigap Plan

Medigap plans are typically open for enrollment year-round. Medigap plans may require enrollees to complete a health history application and may deny coverage due to current or past health conditions (medical underwriting) unless the enrollee is eligible for "guaranteed issue" rights including:

- Enrollment during the 6-month federal open enrollment window that begins with the effective date of Part B coverage
- 12-month trial periods for Medicare Advantage plans
- Enrollment during a Special Open Enrollment Period offered by the plan
- Enrollment related to loss of other coverage due to a "qualifying event"

Contact your local carrier for additional details about Medigap eligibility and enrollment.

Medicare Cost Plans

Similar to Medicare Advantage (Part C) plans, Medicare Cost plans are offered by private insurance companies or organizations that hold an annual contract with the federal government. These plans are the first generation of plans to involve administration of Medicare benefits by private companies. In some ways, Cost plans are the forerunners of Medicare Advantage.

Who's Eligible for a Medicare Cost Plan?

Individuals are eligible for a Medicare Cost plan if they:

- Are a permanent resident of the service area in which the plan is offered
- Are enrolled in Medicare Part A and Medicare Part B **or** Medicare Part B only
- Continue to pay the Part B premium

Beneficiaries with end-stage renal disease (ESRD) may not be eligible to enroll. Exceptions to the ESRD limitation include:

- An ESRD patient who has had a successful kidney transplant
- An ESRD patient who was previously covered on a group plan offered by the carrier with coverage for the ESRD diagnosis or another MA plan offered by the same carrier

When to Enroll in a Medicare Cost Plan

Medicare Cost plans are typically open for enrollment year-round and never require medical underwriting. Contact your local carrier for additional details about Medicare Cost plan eligibility and enrollment.

Summary

- Enrollment in Medicare Part A is designed to be automatic for qualified individuals at age 65. Eligible beneficiaries not yet collecting Social Security benefits must actively enroll by contacting the Social Security Administration.

- Enrollment in Medicare Part B is voluntary during specified enrollment periods and requires payment of a monthly premium.

- During the Annual Enrollment Period (AEP), from October 15 through December 7 each year, all eligible beneficiaries may enroll in, disenroll from or make a change to their PDP, MA or MA-PD plan.

- During the Medicare Advantage Disenrollment Period (MADP), from January 1 through February 14 each year, beneficiaries may disenroll from the MA or MA-PD plan they are enrolled in. Beneficiaries who disenroll will return to Original Medicare and may enroll in a stand-alone prescription drug plan.

- The Initial Enrollment Period (IEP) is when a newly eligible person may apply for Medicare Part D coverage.

- The Initial Coverage Election Period (ICEP) is the period in which a newly eligible person may enroll in an MA or MA-PD plan.

- A newly eligible beneficiary electing an MA-PD plan uses both the ICEP and IEP simultaneously.

- There are numerous situations that may result in a beneficiary having a Special Enrollment Period (SEP) including but not limited to:
    - Change in permanent residence
    - New or continued eligibility for Low Income Subsidy (LIS) or Medicaid benefits
    - Termination of Plan Sponsor's contract with CMS
    - Changes in employer/union group health benefits
    - Trial periods (typically 12 months) related to Medicare Advantage enrollment
    - Opportunity to enroll in a plan with a 5-Star Rating from Medicare

2. Medicare Parts A-D Basic Benefits

Table of Contents

Introduction

Learning Objectives

At the end of this section you will be able to:

- Describe and differentiate between Medicare Parts A, B, C and D
- Define Medicare Advantage, Medigap and Medicare Cost plans
- Identify different types of Medicare Advantage Plans
- Describe the standard Part D plan structure

Whether you're new to Medicare or experienced with Medicare market offerings, this lesson includes critical information about key concepts and recent changes in the Medicare landscape. This lesson, Medicare Parts A-D Basic Benefits, provides an important foundation for other courses on specific Medicare products.

What Is Medicare?

Medicare is a federal program that provides health care coverage to people who are age 65 and older or have certain disabilities. Medicare and Medicaid were enacted in 1965 as part of the Social Security Act to provide health insurance for the aged and to complement Social Security Title II benefits. The program is administered by the Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services.

In 1972, Medicare eligibility was expanded to include individuals under age 65 with certain long-term disabilities and to individuals with end-stage renal disease (ESRD). Over the years additional changes were legislated to payment schedules for providers and beneficiaries. The most recent and significant changes were the result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which improved access to care for Medicare beneficiaries. The MMA added prescription drug benefits, new Medicare supplement choices, new Medicare Advantage choices, and income indexing that ties the premium cost to the beneficiary's income for Part B benefits.

Medicare Today

The Medicare market is a growing and changing part of the American health care system. The number of Medicare-eligible individuals is expected to grow to 62 million by 2020 as baby boomers begin to reach age 65. This is a significant increase from 1965 when only about half of seniors had insurance coverage. When Medicare was implemented in 1966 more than 19 million individuals enrolled on July 1.

Looking toward the future, baby boomers will have a significant impact on the Medicare program. There are an estimated 78.2 million baby boomers born between the years of 1946 and 1964. The first baby boomers turned 65 in 2011 and are now eligible for Medicare. By 2030, an estimated 57.8 million baby boomers will be between the ages of 66 and 84. We can expect additional changes to Medicare as this generation reaches retirement age.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

The MMA introduced prescription drug benefits by first creating a prescription drug discount card effective until 2006 at which time the new voluntary Part D outpatient prescription drug benefit became available. It also introduced new Medicare supplement choices (plans K and L), benefits, and delivery options for Medicare beneficiaries. The MMA created price indexing related to the premium charge for Original Medicare Part B benefits beginning in 2007. This act also allowed Medicare to consider beneficiary income for the first time and made prescription drug subsidies available to beneficiaries with incomes of less than 150% of the federal poverty limit. The MMA also allowed for competition among health plans to foster innovation and flexibility in coverage, authorized coverage for new preventive benefits, and made numerous other changes.

The MMA was designed to improve access to care for people with Medicare and to respond to changes in the nation's economy and health care delivery system. Though the Medicare program has been modified many times since its inception, the MMA represents the most significant reform to the Medicare Program since 1965.

The key reforms introduced by the MMA were scheduled to roll out over three years:

2004	2005	2006
▪ Drug Discount Card ▪ Changes to Medicare Advantage (Part C): o Private-fee-for-service plans offered o Local PPO and HMO plans offered ▪ Moratorium on therapy caps until January 1, 2006	▪ Drug Discount Card ▪ New preventive services ▪ Part B deductible increases ▪ First Annual Enrollment Period	▪ Medicare Prescription Drug (Part D) plans effective (end of Drug Discount Card program) ▪ Medicare Advantage Regional PPOs offered ▪ Medigap: new plans K & L added

To learn more about Medicare or the MMA, visit Medicare.gov.

Medicare Coverage

Medicare is separated into four parts:

- Part A, Hospital Insurance (Original Medicare)
- Part B, Medical Insurance (Original Medicare)
- Part C, Medicare Advantage Program (established in the 1997 Balanced Budget Act as Medicare + Choice and reformed under the Medicare Modernization Act (MMA) in 2003)
- Part D, Prescription Drug Program (part of the 2003 MMA reforms and effective January 1, 2006)

Original Medicare

Medicare pays for about half of all beneficiary health care spending, and was never intended to cover all health care costs. It consists of two parts – Part A which helps cover inpatient care in hospitals and skilled nursing facilities and Part B which helps cover medical services like doctors' visits, outpatient care and other medical services not covered by Part A. The two parts together are referred to as Original Medicare.

Original Medicare generally requires cost sharing in the form of deductibles, copays and coinsurance for most services. Some medical expenses are not covered at all by Parts A or B.

Medicare Part A – Hospital Insurance

Part A is part of the Original Medicare program introduced in 1965. Often referred to as Hospital Insurance, it covers medically necessary:

- Inpatient hospital stays, including inpatient mental health care
- Skilled nursing facility care
- Hospice care
- Home health services
- Blood at a hospital or skilled nursing facility during a covered stay

Medicare-approved inpatient hospital care is covered based on a "benefit period." A benefit period begins the day a beneficiary goes into a hospital or skilled nursing facility. The benefit period ends when the beneficiary hasn't received any inpatient hospital care (or care in a skilled nursing facility) for 60 days in a row. If a beneficiary is discharged and readmitted to a hospital or skilled nursing facility within 60 days, the previous benefit period continues. If a beneficiary goes into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

Beneficiaries are responsible for deductibles and coinsurance related to their Medicare Part A benefits. The deductible and copay amounts beneficiaries pay in 2016 for each Medicare-approved hospital stay within a benefit period are:

- Days 1-60: Deductible of $1,288*
- Days 61-90: Copay of $322* per day
- Days 91-150: Copay of $644* per day (lifetime reserve days)
  *These numbers may change for 2017

Lifetime reserve days are 60 extra days of Part A coverage members can use in their lifetime. They are not renewable.

- Part A and Part B deductibles, coinsurance and copays are subject to change each year.
- Call 1-800-MEDICARE or visit Medicare.gov for updated information.

Skilled nursing facility care is covered following a three-day inpatient hospital stay for a related illness or injury. Care is covered for up to 100 days in a benefit period. This type of care cannot be long-term care, such as becoming a resident of a nursing home. A beneficiary's copay for each Medicare-approved skilled nursing facility stay within a benefit period in 2016 is:

- Days 1-20: Nothing – Medicare pays the full cost
- Days 21-100: Copay of $161* per day
- Days 101+: 100% of the costs
  *This number may change for 2017

Medicare also covers home health and hospice care. Home health care is limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services, including therapy, social services and medical equipment and supplies. Medicare covers 100% of the cost of medically necessary home health care services except for 20% coinsurance that beneficiaries pay for medical equipment.

Hospice care is for people with a terminal illness who have a life expectancy of six months or less, and includes coverage for drugs for pain relief, medical and support services, and other services such as grief counseling. Medicare covers 100% of the cost for most hospice care. Beneficiaries must pay a $5 copay for outpatient prescription drugs and 5% of the cost for any inpatient respite care (short-term care given by another caregiver so the primary caregiver has a break).

Medicare Part B – Medical Insurance

Medicare Part B is the second part of Original Medicare. Although Part B coverage is discussed at the time the beneficiary enrolls in Part A, there is more flexibility for enrollment in Part B coverage. Part B helps cover medically necessary **outpatient** care including:

- Doctor visits
- X-rays and laboratory services
- Ambulance services
- Emergency or urgent care
- Therapy and rehabilitative care
- Chiropractic services
- Outpatient mental health care
- Outpatient surgery and other procedures
- Certain preventive screenings and tests, such as colorectal screenings, bone mass measurements, cancer screenings, cardiovascular screenings, diabetes screenings, glaucoma tests, mammograms, pap test and pelvic exam, and prostate cancer screenings
- Yearly "Wellness" visit in addition to the "Welcome to Medicare" exam
- Diabetic self-management training and diabetic testing supplies
- Durable medical equipment and prosthetic/orthotic items
- Flu, Hepatitis B and pneumococcal shots
- Kidney dialysis services and supplies
- Home health services not covered by Part A
- Other medical services that Part A doesn't cover

Most Medicare Part B services are subject to an annual calendar-year deductible. In 2016, the deductible is $166. This number may change for 2017. Once the beneficiary has met the deductible, most Medicare-eligible services are covered at 80% leaving the beneficiary responsible for the remaining 20%. Exceptions to this are preventive services, including the "Welcome to Medicare" preventive visit and yearly "Wellness" visits, home health services and clinical laboratory services which are covered at 100%.

What's Not Covered by Original Medicare

This list represents some of the services not covered by Medicare Part A and/or Part B:

- Acupuncture
- Cosmetic surgery
- Custodial care at home or in a nursing home
- Deductibles, coinsurance and copays
- Dental care and dentures (with only a few exceptions)
- Some diabetic supplies (others may be covered by Part D)
- Routine vision care and most eyeglasses
- Routine foot care
- Hearing aids and hearing exams
- Most prescription drugs (may be covered by Part D)
- Services received outside the United States (with limited exceptions)

Medicare Part C – Medicare Advantage

Originally called Medicare + Choice, Medicare Advantage plans are designed to offer more health care coverage choices and better health care benefits for beneficiaries. Medicare Advantage (MA) plans are health plan options that are approved by Medicare and administered by private companies. They are part of the Medicare program and sometimes called Part C.

MA plans replace Original Medicare benefits and are an alternative to Original Medicare plus Medigap or Medicare Cost plans. MA plans are offered by private health plans based on an annual contract with CMS. Medicare pays a capitated rate to the private health plan to administer Original Medicare benefits for its members. The MA plan may also charge an additional premium to offer a higher level of benefits than Original Medicare and/or incorporate Part D prescription benefits into the MA plan creating a Medicare Advantage-Prescription Drug (MA-PD) plan.

Benefits and premiums may change on an annual basis and members who join an MA plan use the health care card provided by the plan. Members are replacing the benefit structure of their Original Medicare benefits with the benefits offered by the MA plan in which they've enrolled. MA plan members do not have access to Original Medicare benefits but are still enrolled in the Medicare program and have all the rights and protections of Original Medicare.

Types of Medicare Advantage Plans

Medicare Advantage plans are available with and without Medicare Part D prescription drug coverage. If they cover drugs, the plans are referred to as MA-PD plans. There are three main types of Medicare Advantage plans:

- Medicare Advantage Coordinated Care plans, including:
  - Health maintenance organizations (HMO)
  - Local or regional preferred provider organization (PPO) plans
  - Medicare Advantage Special Needs Plans (SNP)
- Medicare Advantage private fee-for-service (PFFS) plans
- Medicare Medical Savings Account (MSA) plans

SNP and MSA plans have very unique benefit structures. The other three types of plans have somewhat similar benefit structures with defined copay and/or coinsurance benefits. Where HMO, PFFS and PPO plans differ most significantly is in their provider contracting structures.

Medicare Advantage Coordinated Care Plans

Coordinated Care plans use contracted networks of doctors, hospitals, and other health care providers. A Coordinated Care plan can reduce out-of-pocket expenses for deductibles and co-payments. It may also offer unlimited coverage of some benefits that have limits under Original Medicare. Benefits vary from plan to plan.

Health Maintenance Organizations (HMO)

Usually, members of these plans must select a **primary care physician** to coordinate all of their health care needs and **obtain referrals** for services outside their primary care clinic. Members do not typically have out-of-network benefits except for:

- Medical emergencies
- Urgently needed care outside of the plan's service area
- Out-of-area renal dialysis

HMOs typically do not pay for non-referred care.

Preferred Provider Organizations (PPO)

PPO plans have **contracted provider networks**. Members may use any in-network provider to receive in-network benefits. Members do not have to choose a primary care physician or clinic and never need referrals.

PPO plans also offer **defined out-of-network benefits** that cover eligible services at a reduced benefit level leaving the member with a higher out-of-pocket cost.

Special Needs Plans (SNP)

SNPs are designed to meet the needs of people with unique chronic health conditions and/or financial situations. They help manage and coordinate the multiple services and providers that these members need. Typically SNPs are available to people who:

- Live in institutions such as nursing homes,
- Are eligible for both Medicare and Medicaid or,
- Have one or more specific chronic or disabling conditions.

SNPs may design their plan to cover people in just one of these groups, but may also offer the plan to others.

Medicare Advantage Private Fee-For-Service (PFFS) Plans

A PFFS plan can reduce out-of-pocket expenses for deductibles and copays. The PFFS plan, not Medicare, decides how much the plan pays and how much the member pays for medical services. The PFFS plan must pay providers at a rate that does not put the provider at financial risk.

PFFS plans may or may not have direct contracts with providers. If they choose NOT to have signed contracts with providers, they must pay providers rates that are equal to or greater than Original Medicare payments.

In general, PFFS plan members may go to any provider that is:

- Eligible to be paid by Medicare **AND**
- Willing to accept the payment terms of the plan.

Services provided to a PFFS member by a provider will classify that provider into one of three provider types:

- **Direct-contracting** providers have a signed contract with the MA organization;
- **Deemed-contracting** providers:
  - Are aware in advance that the person receiving services is a PFFS member;
  - Have reasonable access to the terms and conditions of plan payment; and
  - Are providing services covered by the plan
- **Non-contracting** providers do not have a direct contract and are not deemed.

Medicare Medical Savings Account (MSA) Plans

MSA plans combine a high deductible Medicare Advantage (MA) Plan with a Medical Savings Account. MSA plans are not available in all areas.

Medicare Advantage Plan Overview

HMO plans generally:

- Require members to choose a primary physician or clinic
- Require members to obtain referrals for services outside their primary clinic
- Do not offer out-of-network benefits except for emergency or urgent care

PPO plans:

- Have contracted provider networks
- Offer specific out-of-network benefits
- Do not require members to choose primary care providers
- Do not require members to request referrals

PFFS plans:

- May or may not have contracted providers
- Allow plan members to go to any provider that is eligible to be paid by Medicare AND is willing to accept the terms of the plan's payment.

Contact your local plan for additional details on Medicare Advantage plans that may be available in your state.

Medicare Part D – Prescription Drug Coverage

Established as part of the MMA, Part D became effective January 1, 2006. This program offers prescription drug benefits and catastrophic prescription drug protection to all eligible Medicare beneficiaries.

Part D coverage is provided by private health insurance companies and organizations through annual contracts with CMS. Members may purchase Part D coverage in one of two ways:

- As a stand-alone Prescription Drug Plan (PDP) in addition to Original Medicare and certain other Medicare plans, or
- As prescription drug coverage included as part of a Medicare Advantage plan (MA-PD), such as an HMO or PPO

Medicare Part D may be purchased to complement PFFS, Medigap or Medicare Cost plans even if they are from other carriers. Medicare Part D may also be purchased by beneficiaries who are enrolled in Original Medicare only.

The MMA established a standard Medicare Part D plan design illustrated next. Some PDPs and MA-PDs offer coverage or options greater than the standard benefit for an additional premium.

Medicare Part D plan design for 2017:

<table>
<tr><th>Annual Deductible</th><th>Initial Coverage</th><th>Coverage Gap ("Donut Hole")</th><th>Catastrophic Coverage</th></tr>
<tr><td>$400</td><td>Member pays 25%;
Plan pays 75%</td><td></td><td></td></tr>
<tr><td colspan="2">When total Rx costs reach $3,700, members reach the coverage gap</td><td colspan="2">Members pay no more than 40% of the total cost of some brand-name drugs while in the coverage gap. The 50% discount paid by the pharmaceutical manufacturer will still apply to getting out of the coverage gap, but the 5% paid by the member's plan will not count toward the member's TrOOP. Members will pay 51% coinsurance on generic drugs while in the coverage gap.</td></tr>
<tr><td colspan="3">When total out-of-pocket costs reach $4,950, members reach catastrophic coverage benefits.

The member's cost is commonly referred to as "True out-of-pocket" costs or "TrOOP."</td><td>Member pays the greater of 5% coinsurance or a $3.30 copay for generic drugs or a $8.25 copay for brand-name drugs</td></tr>
</table>

Other programs are available to help beneficiaries manage their out-of-pocket costs, including extra help for people meeting specific low-income criteria. For more information on Low Income Subsidy, see section 5.

Network Pharmacies

The health plan contracts with the pharmacies to provide Part D benefits to members. CMS requires that members purchase their prescriptions from network pharmacies, except when circumstances prevent them from reasonably using a network pharmacy.

Using network pharmacies reduces members' costs since members can purchase drugs at a pre-negotiated discounted price. Network pharmacies must also collect any member copay/ coinsurance amounts and file claims electronically for members. **Medications purchased outside the U.S. are not covered by Part D plans.**

Formulary

A formulary is the list of drugs the plan will cover. Medicare requires each plan to cover a minimum of two prescription drugs within each therapeutic classification. Formularies may also be divided into "tiers" and benefits may vary based on which tier a particular drug is on. Drugs not listed on the formulary are not covered, unless an exception request filed by the member and his/her physician is approved by the plan. The exception process is described in the plan's formulary list.

Formularies are subject to change during the year as new drugs are approved by the FDA, as generic forms of brand-name drugs become available, or if a drug is recalled by the FDA.

Excluded Drugs

CMS has determined that there are a number of drugs that will NOT be covered by any Medicare Part D plan, including but not limited to:

- Barbiturates (those not used for the treatment of epilepsy, cancer or a chronic mental disorder)
- Benzodiazepines (those not used for the treatment of epilepsy, cancer or a chronic mental disorder)
- Over-the-counter (OTC) medications
- Compound drugs
- Non-FDA approved medications
- Drugs used to promote fertility
- Drugs used for cosmetic purposes
- Drugs used to treat erectile dysfunction

Excluded drugs are NOT eligible for exception requests. ***Excluded drugs are also subject to change during the year.*** Some Part D plans may include these drugs on their formulary but they are not eligible for Part D coverage and purchases will NOT be applied to the total prescription drug costs or the member's TrOOP calculation.

Other Programs and Supplements

To help beneficiaries manage the out-of-pocket health care costs that Original Medicare leaves behind, and provide more choices and benefits, additional programs and supplements are available:

- Medigap plans, such as Medicare Supplement or Select plans
- Medicare Cost plans

Medigap Plans

Individuals with Original Medicare (both Parts A and B) may purchase a Medigap policy – also known as Medicare supplement insurance – from private insurance companies or organizations. Medigap insurance pays Medicare's deductibles and/or coinsurance/copays and may also offer coverage for services not covered by Original Medicare. Medigap plans coordinate with Original Medicare as secondary insurance coverage.

Medigap policies are regulated by state insurance authorities within guidelines set by the federal government. Prior to the MMA in 2003, there were 10 standardized plans (A-J) available in most states.

Two new standard Medigap plans became available in 2006 (K and L), although companies may not be actively marketing or selling those plans. Plans K and L offer a higher member cost-sharing amount but often have less expensive premiums than the other standard plans.

There were changes to the standard Medigap plans for coverage purchased on June 1, 2010, or later. Following are some highlights of the changes.

- Medigap plans E, H, I and J are no longer available for new sales. Members already enrolled in those plans can continue their current coverage.
- Two additional lower cost options – plans M and N were introduced.
- Preventive care and at home recovery benefits were dropped from all plans. This was done because Medicare covers these services at 100% in most cases.
- New hospice benefits were added to all plans.

Additional information about the new plans is available from carriers that offer the new plans.

Three states – Massachusetts, Minnesota and Wisconsin – do not offer the original 10 standardized plans, although Plans K, L, M and N may be available. Carriers in these states offer plans with somewhat different benefit packages. Among these is an option called Medicare Select, a preferred provider Medigap plan.

Medicare Cost Plans

Medicare Cost plans are similar to Medicare Advantage plans but there are differences. Similar to Medicare Advantage (Part C) plans, Medicare Cost plans are offered by private insurance companies or organizations that have an annual contract with the federal government. These plans are the first generation of plans to involve administration of Medicare benefits by private companies. In some ways, Cost plans are the forerunners of Medicare Advantage.

Cost plan sponsors are reimbursed for actual claims costs plus administrative fees. Cost plans coordinate with Original Medicare for Part A services, but function as the single, primary payer for most Part B services. They are often referred to as a "hybrid" between Medigap and Medicare Advantage plans.

Summary

- Medicare is a federal program, administered by CMS, that provides health care coverage to people who are age 65 and older or who have certain disabilities or end-stage renal disease (ESRD).

- The Medicare Modernization Act of 2003 introduced a prescription drug benefit as well as new health plan choices, benefits and delivery options for Medicare beneficiaries.

- Medicare consists of four parts:
  - Part A: Hospital insurance (Original Medicare)
  - Part B: Medical insurance (Original Medicare)
  - Part C: Medicare Advantage plans
  - Part D: Prescription drug coverage

- Parts A and B are considered Original Medicare.

- Parts C and D were added through subsequent acts of Congress.

- With a Medicare Advantage (MA) plan, Medicare pays a monthly amount to a private company to administer Original Medicare coverage for its members.

- MA plans replace Original Medicare, and some MA plans require payment of monthly premiums for extra benefits and options.

- MA plans include HMOs, PPOs, SNPs and PFFS.

- Medicare Part D, the first comprehensive prescription drug benefit, was made available beginning January 1, 2006.

- Beneficiaries may elect Part D coverage as a stand-alone prescription drug plan (PDP) or as part of a Medicare Advantage plan that includes prescription drug coverage (MA-PD).

- The Part D Standard Plan Design is the building block of all Part D plans and includes an annual deductible, specified cost-sharing, out-of-pocket maximums and catastrophic coverage.

- Medigap and Medicare Cost plans may be purchased to supplement Original Medicare benefits.

- These plans are designed to reduce or eliminate Medicare's deductibles, copays and/or coinsurance, offering beneficiaries more comprehensive medical coverage.

3. Medicare Marketing Guidelines

Table of Contents

Introduction

Learning Objectives

At the end of this lesson you will be able to:

- Explain why compliance is important
- Identify what sales persons and Plan Sponsors need to do to be compliant
- Describe compliant marketing materials
- Understand the rules for compliant marketing and sales practices, including promotional events and solicitation
- Understand the sales monitoring and oversight functions used to ensure compliance
- Understand the impact of Fraud, Waste and Abuse and be able to identify how to report suspected instances

The Centers for Medicare & Medicaid Services (CMS) establishes compliance requirements for all categories of a health plan's operations, including sales and marketing. When violations of these regulations and/or guidelines occur, CMS has the authority to impose civil monetary penalties and/or take other actions.

CMS expects that Plan Sponsors and all individuals engaged in Medicare business will comply with all laws, rules and regulations, including federal and state regulating requirements that apply to the Medicare program.

It is imperative that all of the regulations and guidance regarding marketing and sales of Medicare products as set forth by CMS are followed by Plan Sponsors and in turn by their business partners.

Compliance is obedience to, conformity with and/or fulfillment of the rules and regulations described by CMS. Compliance is important because it:

- Protects the beneficiary's rights
- Ensures that product suitability is taken into account for each beneficiary
- Acts as an equalizer that requires all Plan Sponsors and sales persons to appropriately market Medicare products within the same guidelines

Your Responsibilities as a Sales Person

Sales persons such as independent agents, brokers, employees of the Plan Sponsor and other marketing entities are contractually obligated to the plan. Because of this contractual obligation, CMS considers sales persons to be an extension of the Plan Sponsor and therefore subject to all CMS mandated requirements. By following CMS requirements, you can ensure that both you and the Plan Sponsor are protecting members' rights and remaining compliant with rules and regulations.

For the purposes of this lesson, you will need to understand how certain terms are defined.

- **Sales Person** encompasses independent agents, brokers, employees of the Plan Sponsor and other marketing entities contractually obligated to the plan.

- **Medicare Products** encompasses any Medicare Advantage, Medicare Part D and/or Medicare Cost plan offered by your local carrier(s). (Medigap products that local plans may offer are subject to separate state and/or federal guidelines – contact your local plan for more information on these products.)
- **Plan Sponsor** refers to any health plan with a CMS contract.

Plan Sponsors are accountable to CMS for:

- Training sales persons on the Medicare program, compliant marketing and sales functions and the plan-specific products being offered
- Communicating relevant information to sales persons to ensure continued compliance
- Conducting sales monitoring and oversight to ensure sales persons comply with CMS regulations
- Taking action to correct compliance violations

CMS Marketing Requirements

CMS developed the Medicare Marketing Guidelines to describe the marketing requirements for Plan Sponsors and sales persons. The guidelines include rules for both required marketing materials and appropriate sales and marketing practices. To view and/or print a copy of this document, open the Medicare Marketing Guidelines file in the attachments tab of the Marketing Guidelines course, or search for it at cms.gov.

CMS defines marketing as:

Steering, or attempting to steer, a potential enrollee toward a plan or limited number of plans, or promoting a plan or a number of plans.
Educational events do not constitute marketing.

Marketing by a person who is directly employed by an organization with which a Plan Sponsor contracts to perform marketing, or by a downstream marketing contractor, is considered marketing by the Plan Sponsor. The Plan Sponsor must:

- Use only agents and brokers who are appropriately licensed to sell Medicare products under the laws of the state where they are marketing.
- Comply with all CMS marketing guidelines and applicable Federal and State laws, including anti-kickback laws, fraud and abuse laws and the CMS regulations that prohibit offering beneficiaries an incentive to enroll.
- Monitor the actions of all agents selling their plan(s) to ensure compliance with CMS marketing guidelines and legal requirements.

Because CMS requires the use of appropriately licensed sales persons, CMS expects Plan Sponsors to:

- Cooperate with CMS in the review of any sales person when complaints are made by any source, and CMS determines it is appropriate to investigate
- Report the termination of any brokers or agents, and the reasons for the termination, to the State in which the broker or agent has been appointed

Plan Sponsors and sales persons cannot charge a beneficiary a marketing fee outside of the approved premium. All costs associated with the marketing of a plan are the responsibility of the Plan Sponsor and/or sales person.

Sales persons' compliance with rules and regulations set forth by CMS is the responsibility of the Plan Sponsor and the sales person. Compliance expectations and requirements are identified through proper training and communications. Local plans are also responsible for enforcing state-specific rules and regulations.

Based on CMS' marketing guidance, all sales persons who market and sell Medicare products must meet the following requirements:

- Maintain appropriate licensure in the state(s) in which they sell (the need for a specific license may vary depending on your state)
- Maintain appointment with the local plan(s) in the state(s) in which they sell
- Abide by all contractual obligations related to appointment with the local plan(s)
- Complete training and testing annually on Medicare rules and regulations as well as the details of the products being sold, and receive a passing score of at least 85% on testing related to this training. Specifications for training/testing criteria and documentation requirements will be provided annually by CMS.
- Use only CMS-approved marketing materials or materials that qualify as generic marketing materials and do not have to be submitted to CMS for approval
- Comply with all applicable Medicare Advantage and/or Medicare Part D laws and regulations, CMS rules and guidelines, and all federal health care laws

Meeting these requirements means you may help a beneficiary complete an enrollment election for a plan from a carrier with which you are appointed. However, as a sales person performing marketing, you may not conduct health screening or other similar activities that could give the impression of "cherry picking" or enrolling healthier beneficiaries into specific health plans. You also may not engage in any practice that may appear to deny or discourage enrollment of individuals whose medical condition or history indicates a need for substantial future medical services.

The following activities, which are typically performed by the Plan Sponsor's customer service department, do not require the use of licensed sales persons:

- Providing factual information
- Fulfilling a request for materials
- Taking demographic information to complete an enrollment application at the request of the enrollee

Marketing Guidelines for Medicare Products

Sales persons who have met CMS and Plan Sponsor requirements as described may market government contracted plans in accordance with CMS' definition of marketing (see page 36). This section describes specific sales/marketing activities that are allowed and are not allowed when marketing Medicare products.

Health Care Settings

Sales activities can only be conducted in common areas of health care settings. Scheduling of appointments with beneficiaries living in long-term care facilities is permitted only upon beneficiary request.

- Examples of common areas include: Hospital or nursing home cafeterias, community or recreational rooms, conference rooms
- Examples of restricted areas include: Waiting rooms, exam rooms, hospital patient rooms and pharmacy counter areas (if the pharmacy counter area is located in a retail store, the areas of the store outside of where patients wait to talk with a pharmacy provider or obtain medications are considered common areas)

Prohibition on the Provision of Meals

Meals are not allowed to be provided at any event or meeting where plan benefits and materials are being discussed and/or distributed (sales events) but may be provided at educational events.

Refreshments and light snacks are allowed at sales events but "bundling" is not allowed.

- "Bundling" is defined as providing multiple snack items together that would constitute a meal
- Acceptable snacks that can be provided at sales events may include fruit, raw vegetables, pastries, cookies, bite-size desserts, crackers, muffins, cheese, chips, yogurt and nuts

Scope of Appointments

A scope of appointment form (CMS Model Scope of Sales Appointment Confirmation Form) is required and must be returned to the plan/agent 48 hours prior to the appointment, when practicable, for the following:

- In-home sales appointments
- Personal/individual appointments in sales person's office, coffee shop or similar locations
- When a plan or agent sells more than one type of health care product

A scope of appointment form is also required for walk-ins and must be signed by the beneficiary to confirm the scope of the discussion before the conversation begins. The form should indicate "walk-in" for all walk-in type appointments.

Prior to any personal/individual sales/marketing appointment, the beneficiary must agree to the scope of appointment. This agreement must be documented. The requirements around documentation include:

- The documentation can be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording line, pre-paid envelopes, and email) can be used to document the scope of appointment
- Date of appointment
- Beneficiary contact information (e.g., name, address, telephone number)
- Documentation of beneficiary or appointed/authorized representative agreement
- The product type(s) (e.g., MA, PDP, MMP) the beneficiary has agreed to discuss during the scheduled appointment
- Agent information (e.g., name and contact information)
- An explanation why the SOA was not documented 48 hours prior to the appointment, if applicable
- A statement clarifying that:
  - Beneficiaries are not obligated to enroll in a plan
  - Current or future enrollment status will not be impacted
  - The beneficiary is not automatically enrolled in the plan(s) discussed

A beneficiary may sign an SOA at a marketing/sales event for a future appointment. Marketing/ sales events, as defined in the MMG, do not require documentation of beneficiary agreement.

Note: All business reply cards (BRC) used for documenting a beneficiary's SOA, agreement to be contacted, confirmation of attendance to a sales/marketing event, or request for additional information must be submitted in HPMS. Plan Sponsors should include a statement on the BRC informing the beneficiary that a sales person may call as a result of their returning a BRC.

Only products documented on scope of appointment form can be discussed unless the beneficiary requests additional product information. In this case, if possible, sales persons must document the new request 48 hours in advance. If not possible, the following would apply:

- Additional product discussion requires a new scope of appointment form but a new appointment is not required
- Additional product information can be discussed as soon as a request is documented via new scope of appointment form

Scope of appointment forms must be kept for 11 years and must be provided to the plan or CMS upon request.

Unsolicited Contacts

Organizations and sales persons are not allowed to solicit Medicare beneficiaries through unsolicited contact. This includes, but is not limited to, the following:

- Door-to-door solicitation at a residence or leaving information such as a leaflet, flyer or door hanger at someone's residence or on someone's car
- Outbound marketing calls including third parties and contacting current enrollees to market non-health care related products
- Telephonic or electronic solicitation including leaving electronic voicemail messages, text messaging or sending unsolicited email messages
- Calls to prospective beneficiaries to confirm receipt of mailed information, except as permitted (see the next topic, "Permitted Calls to Beneficiaries")
- Approaching prospective beneficiaries who attended a sales event, unless beneficiary gave permission at the event for a follow-up call or visit
- Approaching potential enrollees in common areas (parking lots, hallways, lobbies, sidewalks, etc.)
- Calls or visits to beneficiaries who attended an educational event, unless beneficiary called first and this is a return call
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling (except as permitted -- see the next topic, "Permitted Calls to Beneficiaries"), to market plans or products. Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts
- Emails, voicemails, text messages or other forms of electronic communication to beneficiaries unless beneficiary has agreed to receive emails, voicemails, text messages or other forms of electronic communication and provided an email address or phone number to the plan and/or sales person
    - Includes prohibition of renting or purchasing email lists to distribute information about MA, PDP or Cost plans, and may not send electronic communications to individuals at email addresses or on social media obtained through friends or referrals

- Plan Sponsors must provide an opt-out process for beneficiaries who no longer wish to receive email, voicemail or text message communications
- If an individual comments, likes or follows the Plan Sponsor on social media, this does not constitute agreement to receive communication outside the public forum. Plan Sponsors may not initiate separate communications to specific social media users. Pop-ups or targeted advertisements are permitted.

Sales persons can leave business cards and contact information with beneficiaries to give to friends but the referred beneficiary needs to contact the sales person, not the other way around.

Permitted Calls to Beneficiaries
Plan Sponsors may:

- Call beneficiaries who submit enrollment applications to conduct quality control and/or agent/broker oversight activities. Scripts for this purpose, like all other call scripts, must be submitted to CMS for review and approval.
- Call their current MA and non-MA members or use third-parties to contact their current MA and non-MA enrollees about MA/Part D plans. Examples of allowed contacts include, but are not limited to, calls to enrollees aging in to Medicare from commercial products offered by the same organization, and calls to an organization's existing Medicaid/MMP plan enrollees to talk about its Medicare products. However, Plan Sponsors may not conduct unsolicited calls to their Medigap enrollees regarding their MA, Part D or section 1876 Cost plan products. When discussing Medicaid products, Plan Sponsors must follow all applicable Medicaid marketing rules.
- Call their current MA members to promote other Medicare plan types or to discuss plan benefits (e.g., Plan Sponsors may contact their PDP members to promote their MA-PD offerings; Plan Sponsors that are also Medigap issuers may market their MA, PDP or Cost plan products to their Medigap enrollees).
- Call their current members, including via automated telephone notification, to discuss/inform them about general plan information, such as Annual Enrollment Period (AEP) dates, availability of flu shots, upcoming plan changes, educational events and other important plan information.
- Call their members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.
- Call former members after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls nor mailings may include sales or marketing information.
- Under limited circumstances and subject to advance approval from the appropriate CMS Account Manager, call LIS-eligible members that a plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.

- Call individuals who have expressly given permission for a plan or sales agent to contact them; for example, by filling out a business reply card or asking a customer service representative to have an agent contact them. This permission applies only to the entity from which the individual requested contact, for the duration of that transaction, for the scope of the product (e.g., MA-PD plan or PDP) previously discussed or indicated in the reply card.
- Return phone calls or messages from individuals or enrollees, as these are not considered unsolicited contacts.

Telemarketing

While sales persons are expected and encouraged to regularly contact current clients and solicit new business using approved marketing functions, they are not allowed to conduct telemarketing. This restriction includes the purchase of telemarketing lists and "cold calling" potential enrollees. CMS also specifically prohibits the enrollment of beneficiaries through outbound telemarketing calls.

CMS allows only Plan Sponsors and appropriately contracted delegated entities to conduct outbound telemarketing functions due to the complex nature of the requirements, including but not limited to:

- Adherence to Federal Trade Commission requirements for sellers and telemarketers
- Adherence to Federal Communications Commission requirements
- Adherence to applicable state laws
- Compliance with National Do-Not-Call Registry and honoring "do not call" requests
- Abiding by Federal and state calling hours
- CMS requirements for compliant telemarketing scripts
- The need for calls to be recorded

Marketing Guidelines for the Annual Enrollment Period (AEP)

The Annual Enrollment Period is October 15 through December 7 each year. The AEP gives all eligible Medicare beneficiaries the opportunity to make changes to their Medicare Advantage or Part D coverage, such as switching from one plan option to another or changing to a different plan altogether.

Marketing of any new products or plan changes for 2017 cannot begin until October 1. 2017 enrollment forms cannot be solicited prior to October 15, 2016. CMS is aware that some beneficiaries may sign and submit enrollment forms prior to October 15 without solicitation. Submission processes for enrollment forms received prior to the beginning of the AEP will be provided each year by your local plan**.** The online enrollment system will not accept online enrollments prior to the start of the AEP.

Plan Sponsors must stop current year marketing activities to existing beneficiaries once they begin marketing benefits for the new contract year. Prior year materials may be provided upon request and enrollment applications may be processed.

Marketing Materials

All materials that may be viewed by potential enrollees or currently enrolled members must be filed with CMS, except for generic marketing materials described in the following section. Timeframes for filing (and formal approval if necessary) will vary depending on the type of material being reviewed and whether it is based on "model" documents provided by CMS. Plan Sponsors may be granted approval for shorter filing timeframes based on consistent compliance with CMS guidance and regulations***. It is imperative that sales persons follow all instructions communicated by the Plan Sponsor when using marketing materials. Improper or non-compliant use of marketing materials will jeopardize the Plan Sponsor's filing status with CMS which will in turn make it more difficult to provide compliant materials to sales persons in a timely manner.***

CMS defines "marketing materials" as any materials targeted to Medicare beneficiaries which:

- Promote the Plan Sponsor, or any Plan Sponsor offered by the MA organization
- Inform Medicare beneficiaries that they may enroll, or remain enrolled in, a Plan Sponsor offered by the MA organization
- Explain the benefits of enrollment in a Plan Sponsor, or rules that apply to enrollees
- Explain how Medicare services are covered under a Plan Sponsor, including conditions that apply to such coverage

Marketing materials exclude ad hoc enrollee communications materials.

The definition of marketing materials extends beyond the public's general concept of advertising materials to include notification forms and letters used to enroll, disenroll and communicate with members regarding many different membership scenarios. The Internet is considered another vehicle for the distribution of marketing material and therefore the same rules and regulations apply to marketing activities on the Internet.

Certain marketing materials must also state they are available in alternative formats. Organizations are expected to make marketing materials available in any language that is the primary language of more than five percent of the Plan Sponsor's service area. Regardless of the five percent service area threshold, the Multi-Language Insert must be included with the Summary of Benefits and ANOC/EOC and all call centers must have free interpreter services available for calls from non-English speaking beneficiaries. In addition, basic enrollee information is expected to be available to the visually impaired.

CMS has up to 45 days to review and approve many types of marketing material, including enrollment brochures and other documents. CMS must also review marketing activities that will take place on the Internet, including websites and materials available on the Internet. CMS accepts materials filed by Plan Sponsors only and will not accept materials from individual sales persons.

Types of materials that must be filed with CMS include:

- Direct mail including letters, brochures, flyers and invitations to sales presentations
- Sales presentations and handouts for attendees
- Newspaper and other print ads
- TV and radio advertisements
- Enrollment forms and supporting materials such as the Summary of Benefits and Formulary list
- Member materials such as acknowledgement letters, ID cards and brochures describing additional plan benefits
- Outdoor and Internet advertising

Sales persons may only use CMS compliant materials provided by the Plan Sponsor. Use of non-compliant materials produced by a sales person, broker, agent or other third party is a compliance violation and will result in disciplinary action against the sales person and/or Plan Sponsor.

Contact your local plan for information about and access to CMS compliant templates designed for sales persons.

Generic Marketing Materials

Agents and brokers can use marketing materials that are generic in nature and do not include content specific to plan benefits, cost sharing or plan names without submitting those materials to CMS for review and approval. Generic materials may reference different types of products offered by the agent (MA-PD Plans, PDPs, etc.).

Star Ratings Information

Star Ratings information must be distributed when an enrollment form and/or Summary of Benefits is provided to beneficiaries. The Star Ratings information document must also be prominently posted on plan websites. When new Star Ratings are released each October, the Star Ratings information distributed with marketing materials must be updated within 21 days. References to a plan's overall Star Rating must make it clear that the rating is "__ out of five (5) stars." Letters, numbers or a combination of both may be used for the rating. Plan Sponsors with one or more contracts that do not have the same overall rating across contracts must not create or disseminate materials in a way that implies that all of their contracts achieved the same rating. Plan Sponsors must be clear regarding the rating for each contract identified in the material. The appropriate disclaimer must also be included. Star Ratings in marketing materials must not be used to mislead beneficiaries into enrolling in plans based on inaccurate information.

New plans that do not have any Star Ratings information are not required to provide Star Ratings information until the next contract year. However, small plans that do not have complete Star Ratings information due to insufficient sample sizes for certain measures must include the standardized Star Ratings information document with any enrollment form and/or the Summary of Benefits as described above.

Whenever individual measures are mentioned, the Plan Sponsor's overall (summary) rating must be clearly presented with equal or greater prominence. Star Ratings in one category or measure cannot be used to imply a higher overall plan rating than is actually the case. For example, a plan which received a 5-Star Rating in customer service cannot promote itself as a "5-Star plan," when its overall Star Rating is actually only 2-Stars. In addition, plans that are assigned a Low Performer Icon (LPI) by CMS, may not attempt to discredit or refute their LPI status by only showcasing their overall Star Rating. If an MA-PD plan has been assigned an LPI due to either low Part C and/or Part D ratings, the Plan Sponsor must clearly indicate its LPI status when referencing its Star Rating. For example, an MA-PD plan that has a 3-Star overall Rating, but has an LPI because of its low Part C ratings, may advertise that its overall Star Rating is 3, but must also include that it has an LPI for its low Part C performance. The Plan Sponsor must also state that its LPI status means that it received a 2.5 Star or below summary Rating in either Part C and/or Part D ratings for the last three years. In cases where the organization received an LPI due to alternating low performance on Part C and Part D ratings, the most recent low rating must be noted. The LPI icon must be included in all marketing materials that reference the Plan Sponsor's Star Rating. Changes are not permitted to the icon.

Plan Sponsors cannot encourage beneficiaries to enroll based on a claim that if they are later dissatisfied with the plans, they can request SEPs and change to higher-rated plans. If Plan Sponsors wish to respond to CMS-issued beneficiary notices, the proposed response must be approved by CMS prior to use. Prior CMS approval is required unless identical materials have been previously reviewed and approved by CMS. Outreach materials may focus on the efforts of the organization to improve its Star Ratings but cannot:

- Dispute the validity or importance of CMS' Star Ratings
- Dispute the validity of the plan's low rating
- State or imply that the enrollee is responsible for the plan's poor rating and/or needs to take specific actions for the plan's future success

Social Media

Plan Sponsors must submit to HPMS social media (e.g., Facebook, Twitter, YouTube, LinkedIn, Scan Code, or QR Code) posts that meet the definition of marketing materials, specifically those that contain plan-specific benefits, premiums, cost sharing or Star Ratings.

Plan Sponsors must not include content on social/electronic media that discusses plan-specific benefits, premiums, cost sharing or Star Ratings for products offered in the next contract year prior to October 1.

If a Plan Sponsor posts required information to a social media site, that information must also be posted on the Plan Sponsor's official website to comply with the disclosure requirement. Both plan enrollees and members of the public should be able to view the required information without having to join a third-party social media website.

Mobile Applications

Mobile applications (apps) that provide information to current enrollees about their current plan or provide non-plan-specific health information do not require submission to HPMS for marketing review. If the app is targeted to potential enrollees, it must be submitted in HPMS. Plan Sponsors must also provide CMS access to their mobile apps upon request.

If Plan Sponsors do not provide complete plan benefit, premium and copayment information in the app, the selection of information must not be misleading. The app must also instruct beneficiaries where to find complete information.

If the mobile app contains provider and/or pharmacy directory information, it must include and give equal prominence to all in-network providers/pharmacies, although it may limit the information by geographic area and/or by the search criteria. The app must clearly indicate if it limits the information to a geographic area.

CMS Material ID Numbers

Compliant marketing materials filed with CMS will be assigned a material ID number as required by CMS**.** CMS material ID numbers vary by type of material and may not be consistent with other document or form numbers used by Plan Sponsors for other identification purposes.

Please review communication from your local plan for information on how to order and use compliant marketing materials.

Guidelines for Promotional Activities and Items

Promotional activities and items must comply with all applicable federal and state laws and CMS regulations and guidance.

Payments cannot be offered to have a person buy or recommend the purchase of an item or service paid in whole or in part by the Medicare or Medicaid program. Civil monetary penalties may be assessed against a sales person and/or a Plan Sponsor for failure to comply with this rule. Penalties may also be assessed if promotional activities or items fail to comply with the guidance in the Medicare Marketing Guidelines which is outlined next.

“Cross-selling” of other non-health related products, such as annuities and life insurance, is not allowed when marketing and selling to individuals or when conducting presentations of health-related products.

Nominal Gifts

In general, a nominal gift or service may be offered to a beneficiary if the item:

- Has only nominal value (must be worth no more than $15) based on the fair market value of the item or less, with a maximum of $50 per person per year
- Is not a meal, cash or a cash equivalent (for example, gift cards that can be converted to cash, lottery tickets, charitable contributions, etc.)
- Is not used to directly solicit leads or enrollments
- Is offered to ***all*** potential enrollees whether or not they enroll

Organizations are prohibited from using free gifts and prizes as an incentive to enroll. Any gratuity must be made available to all participants regardless of enrollment. If one large gift is enjoyed by all in attendance (for example, a concert) the total retail cost must be $15 or less per person when it is divided by the estimated number of attendees.

Prize drawings are allowed but cannot be used as an inducement for plan enrollment**.** Disclaimer of no obligation for plan enrollment must be anywhere the prize drawing is mentioned which includes pre-event advertising materials.

Contact your local plan for specific guidance related to gifts or prize drawings.

Marketing of Rewards and Incentives Programs

Rewards and incentives programs are for current enrollees only. However, plans may include information about rewards and incentives programs in marketing materials to potential enrollees, as long as those communications:

- Are not used to target potential enrollees
- Are provided to all potential enrollees without discrimination
- Are provided in conjunction with information about plan benefits
- Include information about all rewards and incentives programs offered by the plan, and are not limited to a specific program, or a specific reward or incentive within a program

Note: Nominal gifts that are part of a promotional activity are different from rewards and incentives.

Contact your local plan for more information regarding rewards and incentives program requirements.

Public Sales/Marketing Events

Planned public sales/marketing events cannot be advertised until information about these events has been submitted to CMS by the Plan Sponsor via the Health Plan Management System (HPMS) prior to advertising the event or seven calendar days prior to the event's scheduled date, whichever is earlier.

If an event that has been previously reported to CMS needs to be changed (e.g., cancellations and room changes), an update must be submitted to CMS so it can be uploaded in HPMS at least 48 hours prior to the previously reported event start time. Notifications of cancelled sales events should be made, whenever possible, more than 48 hours prior to the originally scheduled date and time of the event.

If a previously reported event has been cancelled less than 48 hours before its originally reported start time, the Plan Sponsor must notify its Regional Office Account Manager of the cancellation and cancel the event in HPMS. The sales person should also make a good faith effort to notify attendees of the cancellation or have someone on-site for 15 minutes to inform attendees of the cancellation, unless it is impractical to do so.

Contact your local plan for further guidance on the cancellation process for sales/marketing events.

Educational Events

Educational events are events designed to inform Medicare beneficiaries about MA, Prescription Drug or other Medicare programs, but do not steer, or attempt to steer potential enrollees toward a specific plan or limited number of plans. Educational events are held in public venues and do not extend to in-home or one-on-one settings. Plan Sponsors may provide education at a sales or marketing event, but may not market or sell at an educational event. There are two types of educational events, each with its own set of guidelines: Prospective Enrollee and Enrollee-Only.

Prospective Enrollee
Educational events for prospective enrollees may not include any sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. This includes the distribution of any material with plan-specific information (including plan-specific premiums, copayments or contact information). Educational events must be explicitly advertised as "educational," otherwise they will be considered by CMS as sales/marketing events.

The following are examples, but are not limited to, the following acceptable materials and activities by Plan Sponsors or their representatives at an educational event for prospective enrollees:

- Any materials designed to inform potential enrollees about MA or other Medicare programs, but do not steer, or attempt to steer, potential enrollees toward a plan or a limited number of plans. Specifically, any material distributed or made available to beneficiaries at an educational event must be free of plan-specific information (this includes plan-specific premiums, co-payments or contact information), and any bias toward one plan type over another.
- A banner with the plan name and/or logo displayed (using disclaimer guidance).
- Promotional items, including those with plan name, logo, and toll-free customer service number and/or/website. Promotional items must be free of benefit information and consistent with CMS' definition of nominal gift.

- A business card if the beneficiary requests information on how to contact the plan or agent for additional information, as long as the business card is free of plan marketing or benefit information.
- Meals may be provided as described in the Medicare Marketing Guidelines.
- Plan Sponsors may participate in educational health fairs and health promotional events as either a sole sponsor or co-sponsor of an event hosted by multiple organizations as long as the event does not include a sales presentation and is billed as educational. Note: Plan Sponsors that intend to market at these events should not refer to the event as educational and must comply with the requirements in the Medicare Marketing Guidelines.
- Respond to questions asked at an educational event. A response by Plan Sponsor's representative to questions will not render the event as sales/marketing provided that the scope of the response does not go beyond the question asked and enrollment forms are neither distributed nor accepted.

At educational events, Plan Sponsors or their representatives are prohibited from the following:

- Discussing plan-specific premiums and/or benefits
- Distributing plan-specific materials
- Distributing or displaying business reply cards, scope of appointment forms, enrollment forms or sign-up sheets
- Setting up personal sales appointments or getting permission for an outbound call to the beneficiary
- Attaching business cards or plan/agent contact information to educational materials; however, upon a request by the beneficiary, a business card can be provided
- Advertising an educational event and then having a marketing/sales event immediately following in the same general location

Enrollee-Only

Plan Sponsors that hold enrollee-only educational events may not conduct enrollment or sales activities during these events. However, Plan Sponsors may discuss plan-specific premiums and/or benefits and distribute plan-specific materials to enrollees. Educational events must be explicitly advertised as "educational;" otherwise they will be considered by CMS as sales/marketing events. In this context only (i.e., events for existing enrollees only), this discussion of benefits is not considered a sales activity. Any marketing of these events must be done in a way that reasonably targets only existing enrollees (e.g., direct mail flyers), not the mass marketplace (e.g., radio or newspaper ad).

Referral Programs

Plan Sponsors and sales persons may ask for referrals from current members, but may request only names and addresses, not phone numbers. This information can then be used to solicit by mail, not by phone or email**.** Gifts for referrals are subject to the same "nominal gifts" guidelines previously described**.** In addition:

- "Thank you" gifts may be offered for referrals but are limited to a retail value of $15 or less per item ($50 or less for the total of gifts throughout the year)
- Gifts cannot be contingent upon actual enrollment
- Letters sent to members soliciting leads cannot announce that a gift will be offered for a referral
- Payments may not be offered or given to induce the referral of a Medicare or Medicaid beneficiary

Cash promotions may not be used as part of a referral program. Contact your local plan for more specific guidance related to referral programs you wish to implement.

Sales Oversight and Monitoring

As described in the introduction to this section, CMS requires Plan Sponsors to oversee the sales and marketing activities of its sales persons. Your local plan may use several methods to monitor sales and marketing activities including:

- Monitoring rapid disenrollment rates
- Reporting non-certified sales persons
- Member surveys results
- Site visits with sales persons
- Auditing of phone calls

Monitoring Rapid Disenrollment Rates

Rapid disenrollment is defined by CMS as disenrollment from a contracted plan within 90 days of the effective date. Rapid disenrollment rates are monitored to identify disenrollment trends that consistently exceed the plan's average rapid disenrollment rate and/or consistently high disenrollment of members linked to individual sales persons.

CMS requires that marketing and sales practices do not mislead beneficiaries, or encourage "cherry picking" or churning of beneficiaries between plans. CMS and Plan Sponsors are aware that market factors may contribute to increased disenrollment rates at certain times of the year and will take these factors into account during the monitoring process.

Reporting Non-certified Sales Persons

Plan Sponsors monitor reports that provide certification status of sales persons to ensure that only appointed and trained individuals are marketing, selling and servicing Medicare products.

Member Surveys

Plan Sponsors may contact members to request their opinion on the sales process. Survey results are reviewed to monitor trends, complaints and/or concerns associated with the sales process and investigate possible compliance violations.

Verification Letters

Within 15 calendar days following receipt of the application, Plan Sponsors are required to mail an enrollment verification letter to the beneficiary. The purpose of the letter is to ensure the beneficiary is enrolled in the plan he or she requested and that he or she understands the rules applicable to the plan.

- Verification letters are required for all new enrollments facilitated by agents and brokers except enrollments into employer or union-sponsored plans or enrollments from one plan to another plan within a parent organization involving the same plan type or product type (e.g., PFFS to PFFS, D-SNP to D-SNP, PDP to PDP).
- Beneficiaries should be told, during the application process, to expect this letter.
- The verification letter is the responsibility of the Plan Sponsor, not the sales person.

The Plan Sponsor must send a verification letter along with any other required enrollment notice, such as enrollment acknowledgement and confirmation letters.

The letter will inform beneficiaries that if they want to cancel the processing of their enrollment, they must notify the Plan Sponsor within seven calendar days from the date of the letter or the last day of the month in which the enrollment request was received, whichever is later. For AEP enrollment requests, this notification must happen within seven calendar days from the date of the letter or by December 31, whichever is later.

Plan Sponsors are not expected to delay processing the enrollment request while completing the enrollment verification process. If the enrollment request is incomplete upon initial receipt, Plan Sponsors are expected to conduct the enrollment verification process while attempting to obtain the information needed to complete the enrollment request.

Site Visits with Sales Persons

A representative of the Plan Sponsor may travel with and/or visit sales persons to observe their marketing and sales processes.

Call Audits

Recordings of beneficiary calls to sales persons employed by Blue Cross and Blue Shield or by contracted vendors of Blue Cross and Blue Shield are regularly audited to monitor marketing practices.

Fraud, Waste and Abuse

CMS requires every Medicare health plan to have in place a comprehensive plan to detect, correct and prevent fraud, waste and abuse. Having a program in place benefits the federal government, health plans and beneficiaries by saving more than an estimated $100 billion from fraud scams alone.

Plan Sponsors are committed to identifying, preventing, correcting and reporting fraud, waste and abuse. The efforts undertaken as part of these processes are collaborative in nature and involve training and education, monitoring, audits including automated claims system checks, investigating potential problems, and more. Efforts to prevent and detect health care fraud, waste and abuse are cooperative and involve:

- State and Federal Agencies including CMS, the Department of Health and Human Services Office of the Inspector General (OIG), the Federal Bureau of Investigation (FBI), the Department of Justice (DOJ), and the Attorney General's Office
- Service providers such as physicians and pharmacies
- Plan Sponsors and sales persons
- Beneficiaries

Fraud

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Providers, manufacturers, sales persons, plan employees and beneficiaries can all commit fraud. Health care fraud is not just a matter of dollars and cents, but can seriously affect the quality of care received.

Most health care professionals and beneficiaries are honest, trustworthy and responsible. The goal is to identify the few who operate with the intention of using Medicare for personal profit. CMS and Plan Sponsors review, investigate and document fraudulent or abusive acts with respect to provider and member claims, over- and under-utilization, misrepresentation of member application information, misuse of assets and other types of fraud.

Examples of fraud include:

- Double billing – charging more than once for the same service or item
- Using another person's Medicare card to get medical care, supplies or equipment
- Soliciting, offering or receiving bribes, rebates or kickbacks (a kickback is an arrangement between two parties which involves an offer to pay for Medicare business)
- Non-compliant marketing practices used to get members enrolled into a plan
- Dispensing expired drugs, forging prescriptions, and reselling drugs on the black market
- Billing for services that were not furnished and/or supplies that were not provided
- Altering claims forms and/or receipts in order to receive a higher payment amount

Waste and Abuse

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Preventing Fraud, Waste and Abuse

As sales persons marketing and selling Medicare products, you have an obligation to report any suspected fraud or abuse. Report any issues or concerns to:

- MedicareBlue Rx at 1-866-311-4216
- Your local Plan Sponsor contact
- 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week
- Health and Human Services Office of Inspector General Hotline at 1-800-447-8477

Plan Sponsors will not tolerate any form of retribution or retaliation against those who report in good faith known or suspected incidents of non-compliance. Every attempt will be made to maintain the confidentiality of such reports, to the extent allowed by law.

Although most sales persons are knowledgeable and trustworthy, if fraudulent or abusive marketing practices are identified through sales monitoring processes or a complaint, the Plan Sponsor will take disciplinary action.

Federal False Claims Act

The False Claims Act is a federal statute that establishes civil and criminal penalties for any individual or entity who "knowingly presents or causes to be presented" a false or fraudulent claim to the government. A false claim is not just the act of submitting a false claim for services to the government but can also be other actions tied to seeking payment from the government. Violators of the False Claims Act may be required to pay up to three times the amount of damages sustained by the government, as well as additional fines, and may be prohibited from participation in federal health care programs.

Examples of potential false claims include:

- Submitting reports to the government that are not truthful and accurate
- Falsifying enrollment forms

These examples may also be violations of state laws directed at identifying fraudulent activities in government-funded health care programs. Numerous state laws, both civil and criminal, contain penalties for fraud and abuse involving government health care programs.

Under the False Claims Act, you may file a lawsuit on behalf of the U.S. government against individuals and/or entities that you allege defrauded the government by filing false or fraudulent claims. This provision also includes false claims made to State Medicaid and certain other government programs. This portion or section of the False Claims Act is referred to as the "qui tam" or whistleblower provision. Depending on the outcome of the case, a whistleblower may share in a portion of the recovery of Federal damages and penalties. The False Claims Act also includes a non-retaliation provision to protect those who report potential fraud and abuse.

Anti-Kickback

There are special laws governing kickbacks from vendors and suppliers who provide goods and services under federal government contracts and from care providers involved in the Medicare/Medicaid programs. Anti-kickback laws provide for severe criminal, civil and monetary penalties not only for individuals who offer kickbacks but also for Plan Sponsors and involved employees/sales persons who solicit or accept such items.

Disciplinary Actions/Sanctions

As a sales person, you are contractually obligated to the Plan Sponsor(s), with which you are appointed, to abide by all Part D laws, federal health care laws and CMS policies including marketing guidelines to ensure beneficiaries receive truthful and accurate information. If a violation occurs, CMS and other federal agencies can seek civil, criminal and monetary penalties from you and your Blue Cross and Blue Shield organization.

Disciplinary and/or corrective actions imposed on Plan Sponsors and/or sales persons include:

- Notification of violation to sales person and appropriate supervisor(s)
- Withholding or reversal of commission/service fee payments
- Requirement to take or re-take certification or other training
- Removal of sales person from the member's account
- Revocation of certification for the remaining sales year (this means the sales person cannot sell the plan's products for the rest of the year)
- Revocation of sales person's appointment with the Plan Sponsor (that is, termination of the relationship with the Plan Sponsor)
- Monetary penalties ranging from $10,000 to $100,000 per violation
- Suspension of payment to the Part D sponsor

Any sanctions imposed remain in effect until CMS is satisfied that the deficiency on which the determination was based is corrected and not likely to recur.

Your Plan Sponsor may also take disciplinary action against you or terminate your contract for violations of marketing guidelines.

Summary

- Every individual or entity engaged in Medicare business must comply with all applicable federal and state regulating requirements, laws and rules that apply to Medicare products.
- The CMS Medicare Marketing Guidelines describe appropriate marketing and sales functions applicable to Plan Sponsors and sales persons.
- Compliance ensures that a beneficiary's rights are protected throughout the marketing and sales process.
- Compliance ensures that product suitability, not the financial interest of the sales person, is the primary driver in the marketing and sale of a Medicare product.
- CMS defines appropriate marketing functions and compliant materials for the marketing and sale of Medicare products.
- Agents and brokers may use generic marketing materials that are not required to be submitted to CMS for approval as long as the materials do not include specific plan benefits, cost-sharing information or plan names. The materials can reference various types of products the agent sells (MA-PD, PDP, etc.).
- CMS and Plan Sponsors require sales persons to be appropriately licensed, appointed according to state laws, and certified to market and sell Medicare products.
- CMS requires Plan Sponsors to train sales persons and oversee marketing and sales functions to monitor compliance.
- Failure to remain in compliance may result in disciplinary action from either or both CMS and the Plan Sponsor and can include termination of marketing and sales activities for both the sales person and/or the Plan Sponsor.
- Report suspected or actual fraud, waste or abuse to MedicareBlue Rx at the number(s) listed in the Introduction to this guide.

4. Medicare Part D Enrollment Process

Table of Contents

Introduction

This section contains information about CMS' enrollment methods and processes for Medicare Part D plans.

Learning Objectives

At the end of this section you will be able to:

- Understand the importance of determining suitability of a plan
- Understand your responsibility for accurate completion of enrollment forms
- Understand your responsibility for submitting enrollment forms
- Describe to beneficiaries the sequence of events that will occur after they have submitted an enrollment form
- Understand the limited instances in which disenrollment requests will be honored

Beneficiaries with Other Non-Medicare Coverage

Every health care plan and product has different disenrollment requirements. Because of this, sales persons must review a beneficiary's current coverage to determine:

- The suitability of a plan change
- Current carrier disenrollment requirements (can vary depending upon if Medigap, Commercial, Medicare, etc.)
- The impact a new Medicare health plan election may have on the beneficiary's other coverage
- Whether coordination of other health care and/or prescription drug benefits needs to be considered

This is particularly important when a beneficiary is a member of an employer or union group health plan. Beneficiaries disenrolling from non-Medicare health plans should contact their employer's plan administrator or the office that answers questions about their coverage to determine how to disenroll from the group plan and whether they will be able to re-enroll at a later date, and whether there are other consequences of disenrolling from the employer's plan.

If a Beneficiary Has Other Medicare Coverage

Beneficiaries currently enrolled in another Medicare health plan could automatically be disenrolled from that plan once they enroll in another Medicare health plan. Other Medicare health plans include:

- PDP plans
- MA or MA-PD plans
- Medicare Cost plans

Please note: Medicare supplement or "Medigap" health plans are not considered "Medicare health plans" for the purposes of this guide.

Example 1

Jim chooses to enroll in a new PDP plan. Because of this, he will automatically be disenrolled from a current PDP plan or MA-PD plan. His PDP election will **not** affect current enrollment in Original Medicare, including enrollment in a Medigap plan, even if that Medigap plan includes prescription drug coverage. If Jim has a Medigap plan with prescription drug coverage, but decides that the prescription drug coverage offered through the PDP is more suitable for his needs, Jim should contact his Medigap carrier to see how to drop only the prescription drug portion of his current coverage.

Example 2

Myrtle decides to elect a new MA-PD plan. Because of this, she will automatically be disenrolled from a current PDP and/or MA-only plan, MA-PD plan, or Medicare Cost plan. She will **not** be automatically disenrolled from a Medigap plan.

Example 3

Joe wants to make a new MA-PD election. He is currently covered by his former employer's group retiree medical plan. When talking with the plan's administrator, Joe discovers that if he elects any plan other than his current retiree medical plan he will not be able to return to the employer's retiree plan at a later date if he changes his mind. After comparing the benefits he currently has with those he would get in the MA-PD plan, he decides **not** to enroll in the MA-PD plan.

There is a Medicare Advantage Disenrollment Period (MADP) from January 1 through February 14 each year when beneficiaries may disenroll from the MA or MA-PD plan they are enrolled in. Beneficiaries who disenroll will automatically return to Original Medicare and may choose to enroll in a stand-alone prescription drug plan, regardless of whether the plan they are disenrolling from included prescription drug coverage.

For more information and assistance in determining the impact of a beneficiary's plan change, contact the Plan Sponsor.

Enrollment Requirements for Medicare Part D

Once you and the beneficiary determine the suitability of a new plan (one that is based on the beneficiary's needs), the beneficiary's eligibility for that plan, and that a valid enrollment period exists, you're ready to begin the enrollment process.

CMS enrollment requirements include obtaining a beneficiary's electronic or written signature on an enrollment form. This signature verifies:

- The beneficiary's intent to enroll
- That personal information is accurate
- The plan option chosen
- The billing option chosen
- That the beneficiary understands each Enrollment Authorization statement included on the enrollment form

Beneficiaries are responsible for reviewing the Enrollment Authorization statements. Sales persons are responsible for answering any questions the beneficiary may have about the plan and/or the enrollment form before requesting a signature.

Enrollment Step 1: Completion of Enrollment Form

First, determine which method of completing an enrollment form is most appropriate. The following options are available:

- Submit an online enrollment form via the plan/Part D sponsor's website
- Submit an online enrollment form via Medicare.gov
- Complete a paper enrollment form and submit it online
  - Make sure the beneficiary has given permission for their enrollment to be submitted online by checking the authorization box on the paper enrollment form.
  - You need to keep the paper enrollment form for 11 years.
- Complete a paper enrollment form and submit it by fax or overnight delivery
  - If submitting a paper enrollment form by fax, you need to keep the fax confirmation and the paper enrollment form for 11 years.
- Beneficiary completes enrollment via inbound telephone call to plan/Part D sponsor
  - Telephonic enrollment is available only for beneficiaries or their authorized representatives.

Online Enrollment

Sales persons are strongly encouraged to enroll beneficiaries online at YourMedicareSolutions.com whenever possible. Online enrollment:

- Reduces errors and delays due to missing or incomplete information
- Allows immediate receipt of enrollment without delivery delays
- Provides an immediate, printable confirmation that the enrollment was submitted
- Allows a separate email confirmation to be sent
- Is easy to do!

As with a paper enrollment, online enrollment requires beneficiaries or their authorized representative to verify the following:

- Receipt of all required pre-enrollment materials
- Statement of their intent to enroll by electing a plan option
- Accuracy of personal information
- Chosen plan option
- Identification of a valid enrollment period
- Chosen payment (billing) option
- Understanding and acceptance of each Enrollment Authorization statement on the enrollment form (these are also listed online)

In order for a valid online enrollment to occur, beneficiaries (or their authorized representative) **MUST**:

- Complete the online enrollment or give their agent permission to submit their enrollment online
- Be able to view the online application throughout the enrollment process
- Receive a paper copy of the confirmation statement upon submission of the online enrollment
- Receive a separate email confirmation of the online enrollment if requested

Sales persons are not authorized representatives. An **authorized representative** acts on behalf of the individual under the laws of the state where the individual resides. The authorized representative must be authorized under state law to complete the enrollment, and have documentation of this authority available upon request from the Plan Sponsor or Medicare. Authorized representatives include individuals with legal designations such as Power of Attorney or legal guardianship for the beneficiary. Refer to Chapter 3 of the Medicare Prescription Drug Benefit Manual for more on authorized representatives/legal representatives.

If you are assisting beneficiaries in completing paper enrollment forms and plan to submit their enrollments online, there is a section on the application that must be completed by the beneficiary. The beneficiary must check the authorization box below their signature to authorize you to submit their paper application online. You must keep the paper enrollment form on file for 11 years.

Paper applications that are being submitted online should be submitted immediately, but must be submitted no later than two calendar days after the date the agent signs the application.

Sales persons **are not allowed** to submit an online enrollment with information provided by the beneficiary over the phone.

Telephonic Enrollment

CMS allows enrollment via telephone only if the following guidelines are met:

- Enrollment is completed via an incoming call from the beneficiary or the beneficiary's authorized representative to a plan representative
- The telephonic enrollment request is initiated entirely by the beneficiary or his/her authorized representative
- Sales persons **must not** be physically present with the beneficiary at the time of the request
- Independent agents and brokers may be on a three-way call with the pre-enrollment call center and the member to give agent identifier information, but then must disconnect from the call prior to the enrollment of the member
- The telephonic enrollment call is recorded following FCC rules and regulations
- The telephonic enrollment is completed using a CMS-compliant script to ensure that beneficiaries:
    - Understand that they are completing an enrollment election
    - Understand that they are being recorded
    - Attest to the accuracy of required elements
    - Attest to their intent to enroll in the plan

Plan Sponsors generally provide telephonic enrollment support via a contracted or internal call center. A CMS-compliant script is used to complete enrollment and call center representatives are trained to follow CMS guidelines and other procedures necessary for a valid telephonic enrollment.

The phone number for MedicareBlue Rx telephonic enrollment is 1-866-434-2037.

Paper Enrollment

Paper enrollment forms received by sales persons can no longer be submitted by regular mail. They must be faxed or sent by overnight delivery following the instructions below. Applications must be submitted immediately after the agent signs the form.

Faxing and Overnight Delivery

Fax MedicareBlue Rx enrollment forms to: 1-855-874-4702

Each fax cover sheet must include the following information:

- Name of the beneficiary(ies) on the enrollment form(s)
- Number of enrollment forms in that transmittal
- Your name and contact information should the plan need to contact you with questions

If sending MedicareBlue Rx enrollment forms by overnight delivery:
Use this address: TMG Health, Inc.
25 Lakeview Drive
Jessup, PA 18434

When using overnight delivery, make sure you have the correct street address (overnight deliveries cannot be made to a P.O. Box).

If you need more information, call the Plan Sponsor and/or review communication from your local plan(s).

Payment of Premiums

Beneficiaries will be able to select from available premium payment options when they complete their enrollment. Premium payments should NOT be submitted with a paper enrollment form. Members will be billed via their selected billing option once CMS approves the enrollment and the plan becomes effective.

If a beneficiary wants to sign up for Electronic Funds Transfer (EFT) to have payments automatically deducted from a bank account, they will need to complete an EFT form. Until they complete the form and return it to the Plan Sponsor, they will receive a paper bill. Once the form is received, it may take up to two months for EFT to begin. They should pay the paper bills they receive until EFT takes effect. If they don't pay all the paper bills while EFT is being set up, any amounts they owe will be included in their first EFT payment. Once EFT is active, they will no longer receive a paper bill and will see that payments are withdrawn on their bank statements. Premium payment through EFT can only occur AFTER their coverage is effective.

Beneficiaries can also choose to have payments deducted from their Social Security or Railroad Retirement Board (RRB) benefit checks. In most cases, Social Security/RRB will accept their request for automatic deduction. If Social Security/RRB does not approve their request for automatic deduction, beneficiaries will be sent paper bills for their monthly premiums and their request will be resubmitted. Once approved, it can take two or more months to become effective. During this time, they will receive paper bills and be responsible for paying Part D premiums directly to the plan until the month in which premium deductions begin. If they do not pay the paper bills for the months in which the deduction was not in effect, they may be disenrolled from the plan. Social Security/RRB do not allow any retroactive withholding requests.

Enrollment Step 2: Acknowledgment of Receipt of Enrollment Form

For all enrollment options, the Plan Sponsor is required to call the beneficiary within 10 calendar days of the application date. In addition to this notice, online enrollees may print a confirmation of their enrollment submission and/or request an email confirmation. Telephonic enrollments can also be confirmed via email if requested. Beneficiaries completing paper enrollments must keep a copy of the form.

Application Date

CMS defines the application date for an enrollment form as the date that the enrollment form is received by the plan. Online and telephonic submissions are electronically date-stamped to identify the application date. Paper enrollment forms mailed by a beneficiary directly to enrollment processing centers are date-stamped the day they are received.

Because CMS considers sales persons to be an extension of the Plan Sponsor, **receipt of an enrollment form by a sales person is considered receipt by the plan** and that date is the application date.

For this reason, it's important that you not hold applications, but submit them immediately. If you are unable to submit the application immediately, it must be submitted no later than 2 days after the beneficiary has signed the application. It's also important that you not sign the application before the beneficiary has signed it. Applications received five or more calendar days after the agent signature date will result in corrective action.

The **application date** is the date the enrollment request is received by the Plan Sponsor including receipt by a sales person.

When an enrollment form is NOT date-stamped, it may impact the effective date of coverage for the beneficiary.

Paper enrollment forms received by sales persons MUST be faxed or submitted by overnight delivery to the appropriate enrollment processing center immediately and include documentation of "application date." Paper enrollments may also be entered online immediately after receipt if the beneficiary has given permission for this by checking the authorization box on the form. The date an application is received by the plan is considered to be:

- The date the sales person signs and dates the enrollment form
- The earlier of the date stamp and/or signature date of the sales person or the agency
- The plan/Part D sponsor's mailroom receipt date if there is no sales person signature on the enrollment form

Acknowledgment of Receipt of Election

Once enrollment elections are received, the plan/Part D sponsor has 10 calendar days from the application date to provide the beneficiary with:

- An acknowledgement letter verifying receipt of a complete enrollment form which may be used as proof of coverage until member materials arrive, or
- A telephonic or written request for missing or clarifying information, or
- A written notice that the enrollment was denied based on a determination that the beneficiary was ineligible

Within 15 calendar days of the application receipt date, the beneficiary will receive a verification letter to make sure he or she understands the plan rules.

If the enrollment form is incomplete according to CMS guidelines, the beneficiary will receive a request for the missing information. The beneficiary has 21 calendar days from receipt of the request, or until the end of the month in which the request was received, whichever is later, to supply the missing information. All additional information provided by the beneficiary will be date-stamped as soon as it is received. If the requested information is received within the allowable timeframe, and the election is deemed complete, the plan must forward the election to CMS within seven calendar days. For AEP elections, the beneficiary has 21 calendar days from receipt of this request, or until December 7, whichever is later, to provide the requested information. If the information is not provided in that timeframe, the enrollment request is denied and the beneficiary is notified of the denial.

If an election period cannot be determined on the enrollment application, the enrollment request cannot be sent to CMS for approval. The beneficiary must be contacted and the Plan Sponsor must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. If the election period is validated, the enrollment request must be submitted to CMS within seven calendar days from the receipt of the application. If the election period is not validated, the enrollment request must be denied within 10 calendar days of the application date.

If a beneficiary's election is denied based on ineligibility, it is often because the beneficiary does not reside in the service area or is electing coverage outside of a valid enrollment period. Another reason for denial of an election is if the beneficiary does not provide missing information or does not submit clarifying documentation as requested within the required timeframe. Under these circumstances, the Plan Sponsor must notify the beneficiary of the denial, including the reason for the denial, within 10 calendar days of this determination. When an enrollment is denied by the Plan Sponsor, it means that the election request was *not* submitted to CMS because the Plan Sponsor determined that the election was not valid.

Common Enrollment Form Errors

Some of the most common errors that result in incomplete enrollment forms, delayed processing and/or delayed effective dates, include:

- Not using the beneficiary's legal name as identified by Social Security
- Missing or incorrect date of birth
- Missing, incorrect or incomplete Medicare Claim (HIC) Number
    - This number must include all letters and numbers, such as the letter at the end of the Medicare Claim Number or the letters for Railroad Retirement
    - This HIC number may be that of a beneficiary's current or past spouse
- No plan option selected
- Missing beneficiary signature or the signature of the authorized representative

Enrollment Step 3: Submission to CMS for Approval

Plan Sponsors must submit complete election requests to CMS within seven calendar days so that CMS can confirm the beneficiary's eligibility. While CMS is reviewing the election request, the beneficiary can use the acknowledgement letter that verifies receipt of the complete enrollment form as proof of coverage until member materials arrive.

Enrollment Step 4: CMS Accretion

Accretion is the process CMS uses to review enrollment requests and verify that the beneficiary meets all CMS eligibility requirements. Once CMS has finished its review, it notifies the Plan Sponsor whether the beneficiary's enrollment request is approved or rejected.

Enrollment Step 5: Member Materials

Once the Plan Sponsor is notified that the beneficiary's enrollment request is approved, member materials are mailed. These materials include a confirmation letter, ID card and Welcome Kit. The confirmation letter issued by the plan notifies the beneficiary of CMS' response and must be mailed within 10 days of CMS' notice to the Plan Sponsor. The Welcome Kit includes important plan information, such as the Evidence of Coverage, a formulary, pharmacy list, information on using the mail order pharmacy service and, for Medicare Advantage plans, a provider directory. If the pharmacy list and/or provider directory are not provided as hard copies, there must be a separate notice to alert enrollees where they can find them online and how they can request a hard copy. This is required at the time of enrollment and annually thereafter.

If CMS rejects the enrollment, the Plan Sponsor must also notify the beneficiary of the CMS rejection within 10 calendar days of the notice. The letter will describe the reason that CMS rejected the election request as well as the beneficiary's appeal rights.

Disenrollment Requests

In general, once a Part D plan option has been elected and approved, the member is "locked in" to the chosen plan for the remainder of the plan year (calendar year).

Enrollment into a Medicare health plan during a valid enrollment period will automatically disenroll the beneficiary from another Medicare health plan upon CMS' approval of the newly elected option. A request to disenroll is not required and should not be made.

Exception: Individuals enrolled in MA-only Private Fee-for-Service (PFFS) plans must request disenrollment first, as enrollment in a PDP will not automatically disenroll them from the MA-only PFFS plan.

Limited instances where a request to disenroll may be honored include:

- New eligibility for Veteran's Administration (VA) prescription drug benefits
- New eligibility for employer group or union health benefits
- Electing to disenroll from a Medicare health plan during the AEP without electing another MA, MA-PD or PDP option
- Determination of dual-eligibility or loss of dual-eligibility
- Permanent residence change into an institution (e.g., long-term care facility)

Contact your local plan for additional information about disenrollment requests.

Summary

- The steps in the enrollment process include:
    1. Completion of Enrollment Form
    2. Receipt of Enrollment Form by health plan
    3. Submission to CMS for approval (accretion)
    4. CMS Accretion
    5. Member Materials or rejection letter

- Sales persons assisting beneficiaries with submission of an enrollment form must:
    - Determine if the beneficiary is enrolled in other medical or prescription drug coverage,
    - Work with the beneficiary to determine the impact of enrollment in a Medicare health plan on the beneficiary's current coverage AND
    - Determine if coordination of benefits with other coverage needs to be considered.

- Sales persons assisting beneficiaries with submission of an enrollment form are strongly encouraged to utilize online or paper-to-online enrollment options to expedite receipt of a complete enrollment request and reduce errors

- Paper enrollment forms must:
    - Be reviewed for completeness and accuracy of information
    - Include all required signatures
    - Be date-stamped and/or signed and dated by the sales person and submitted to the appropriate enrollment processing center by fax or overnight delivery as soon as possible, but no later than two days after the date they are signed
    - Be entered online as soon as possible, but no later than two days after the date they are signed
        - Beneficiary permission is required for the sales person to submit the application online. Beneficiaries provide this permission by checking the authorization box on the paper enrollment application

- Beneficiaries are notified in writing when the Plan Sponsor first receives the enrollment request, and again when the election has been approved or rejected by CMS

- Beneficiaries must be notified of receipt of an enrollment form within 10 calendar days of the application date. This notice documents one of the following:
    - Acknowledgement or receipt of a complete enrollment form that may be used as proof of coverage
    - Request for missing information or clarifying documentation
    - Notice of Plan Sponsor denial due to determination of an invalid election

- Beneficiaries are notified in writing of CMS' notification of approval or rejection within 10 calendar days of receipt by the Plan Sponsor; CMS approval will generate member materials

- Generally, disenrollment from one Medicare health plan occurs as a result of a valid enrollment into another Medicare health plan
    - Situations that may result in submission of a disenrollment request are rare and will generally be denied

5. Low Income Subsidy and the Late Enrollment Penalty

Table of Contents

Introduction

Learning Objectives

At the end of this section you will be able to:

- Describe low income subsidy (LIS) assistance available for beneficiaries with limited income and assets
- Provide information to beneficiaries on how to apply for LIS
- Describe the late enrollment penalty (LEP)
- Provide information to beneficiaries on how to avoid the LEP
- Understand the impact of LIS and LEP for beneficiaries enrolled in employer/union group Medicare benefits
- Understand the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Eligibility for low income subsidy (LIS) and the possibility of a beneficiary being assessed a late enrollment penalty (LEP) are considerations that must be taken into account as part of product suitability determination and the enrollment process. Sales persons and plan/Part D sponsors are key in helping beneficiaries understand these topics.

Low Income Subsidy (LIS) Assistance

Even with the coverage provided by Medicare prescription drug plans, premiums and drug costs can still be a financial burden for those with limited incomes and resources. Low income subsidy (LIS) assistance is available to help qualified beneficiaries pay for prescription drug coverage and drug costs. The "extra help" is for people who meet specific income and resource limits. The extra help may pay for some or all of the member's Part D plan monthly premiums, yearly deductibles and/or prescription copays or coinsurance.

LIS eligibility is determined by the Social Security Administration (SSA) or state Medicaid office. Beneficiaries can apply online at ssa.gov, or over the phone by calling the Social Security Administration. Many beneficiaries may not be aware of the help that is available, so sales persons should encourage lower income Medicare beneficiaries to apply for the subsidy through the SSA or their state Medicaid office. Beneficiaries who are determined to be eligible will receive a letter advising them of the level of subsidy for which they qualify. The Plan Sponsor will be notified of an individual's status by CMS during the accretion process and will apply the subsidy accordingly upon final enrollment.

LIS Automatic Enrollment

Individuals with full Medicaid, Supplemental Security Income (SSI) or Medicare Savings Program benefits ***and*** Medicare benefits are considered to be "dually-eligible" and are automatically identified by CMS as eligible for LIS. In this instance, CMS notifies the individual that he or she will be enrolled in a plan chosen by CMS on a specified effective date unless:

- The individual elects a different Part D plan OR
- The individual responds to the notification and "opts out" of Part D entirely.

If neither action is taken, CMS assigns the individual to a prescription drug plan with a premium at or below the low income premium subsidy amount for the plan's region. Though assigned to a plan, dually-eligible members are allowed to change plans each month if desired. Dually-eligible members are eligible for a continuous special enrollment period (SEP) to do so.

Dually-eligible beneficiaries should also be encouraged to seek out Medicare Advantage Special Needs Plans (SNPs) that may be available in their area. SNPs are often designed to meet the unique medical and financial needs of dually-eligible beneficiaries.

LIS Facilitated Enrollment

Beneficiaries who qualify for LIS assistance based on income and assets are identified in one of two ways:

- They are eligible for some level of assistance from the Medicaid program but do not have full Medicaid benefits OR
- They have applied and been approved for LIS assistance through the SSA or their state Medicaid office.

To help a beneficiary determine if they qualify for extra help, the SSA has placed a worksheet and instructions on their website, ssa.gov. The beneficiary will need to know their income and the value of their savings, investments and real estate (other than their home). At the time this guide was created, ssa.gov listed the following income and resource limits for 2016:

- Income must be limited to $17,820 for an individual ($24,030 for a married couple living together).
- Total resources must be limited to $13,640 for an individual ($27,250 for a married couple living together).

Even if the income and resource limits are exceeded, some assistance may still be available. LIS income and resource limits are subject to change each year and beneficiaries should contact SSA for current limits. Additional information about the types of income and resources considered as well as application materials can be found on ssa.gov.

These beneficiaries will also be notified of their LIS eligibility and given a period of time to elect a Medicare drug plan of their choice. If they do not select a plan within that time frame, they will be auto-enrolled in a plan by CMS. They also have the right to change plans monthly if desired with a continuous SEP.

The SSA also sends letters to many LIS eligible or potentially eligible beneficiaries each summer and fall.

LIS Enrollment & Marketing Guidelines

Individuals who are newly qualified for dual-eligibility or LIS assistance but not currently enrolled in a Part D plan have a SEP during which they can elect prescription drug coverage. Individuals currently enrolled in a Part D plan who are newly qualified for dual-eligibility or LIS assistance will have their LIS benefits applied to their current plan. All individuals eligible for dual-eligibility or LIS assistance may change their Part D option on a monthly basis.

The benefit structure of the chosen plan will be replaced by the LIS benefit structure for which the individual qualifies. The member with LIS may pay deductibles, copays and/or coinsurance that are different from the chosen Part D plan design. The member will continue to use the plan's pharmacy network and formulary. LIS eligible individuals should be encouraged to enroll in a Part D plan with a premium at or below the LIS benchmark premium in the plan's region so they can take full advantage of their LIS.

The amount of premium assistance received from the government is based on a number of factors including the average LIS benchmark premium. Calculating the member's actual cost including the subsidy is NOT as simple as subtracting the subsidy amount from the premium cost. This calculation will be done by CMS during the accretion process and forwarded to the Plan Sponsor. Members qualifying for extra help will also receive by mail the "Evidence of Coverage Rider for Those who Receive Extra Help Paying for their Prescription Drugs" that explains the plan's costs for the member.

Employer/Union Group Medicare Plan Enrollees

Premiums charged for an employer/union group Part D plan benefit package can vary among different employer/union group health Plan Sponsors. CMS requires that all Part D sponsors offering group plans ensure that any LIS amount paid on behalf of a LIS beneficiary accrues first to the benefit of the LIS-eligible beneficiary.

Specifically, the LIS premium must first be used to reduce any portion of the monthly Part D premium paid by the beneficiary, with any remaining portion of the premium subsidy amount applied toward the portion of any monthly premium paid for by the employer/union.

Late Enrollment Penalty (LEP)

Enrollment in any Part D prescription drug plan is completely voluntary; however not enrolling when first eligible could lead to higher premium costs later on. Beneficiaries who take no or few medications should still consider enrolling in a prescription drug plan to protect themselves against unexpected changes to their health and prescription drug needs in the future and to avoid the late enrollment penalty (LEP).

Beneficiaries who do not sign up for Part D benefits when first eligible may have to pay a penalty in the form of higher monthly premiums when they enroll later. Beneficiaries who do not sign up during their Initial Enrollment Period (IEP) may not be eligible to sign up again until the next valid enrollment period which means that the penalty can quickly add up.

The LEP is calculated as 1% of the national average premium times the number of full months the member was eligible for Part D but did not enroll. The LEP will be assessed to a beneficiary upon enrollment in a Part D plan if they:

- Did not elect Part D coverage when first eligible AND
- Have been without "creditable prescription drug coverage" for a continuous period of 63 days or more from the end of the IEP.

Creditable Prescription Drug Coverage

Creditable prescription drug coverage is drug coverage that pays, on average, at least as much as Medicare's standard prescription drug benefit. Beneficiaries who have prescription drug coverage as part of a health plan, such as Veterans Administration (VA) prescription drug benefits or prescription drug benefits through an employer group or union plan, should review their current plan carefully and talk to the plan's administrator before making a Part D enrollment decision.

The certificate or notice of creditable coverage an enrollee receives when most kinds of health coverage end may not be adequate notice that the *prescription drug* coverage was as good as Medicare's prescription drug coverage, unless the notice specifically refers to the creditable coverage status of the enrollee's prescription drug coverage. Group members need to determine if their current coverage is creditable prescription drug coverage and whether enrolling in a Part D plan will negatively affect their employer group or union benefits. Employer or union groups offering prescription drug benefits are required to notify Medicare-eligible members each year as to whether or not those benefits are creditable. Members who do not receive such notice should contact their benefits administrator.

If a member currently has prescription drug coverage that is considered creditable coverage, he or she may keep that coverage and wait to enroll in a Part D plan. If they decide to enroll in a Part D plan later, they will not have to pay a late enrollment penalty.

Examples of coverage that likely include creditable prescription drug coverage are:

- Employer-based prescription drug coverage, including the Federal Employees Health Benefits Program (FEHBP)
- State Pharmaceutical Assistance Programs (SPAPs)
- Military-related coverage (e.g., VA, TRICARE)

Because the standard Part D benefits change each year, it is important for beneficiaries to verify whether their current coverage is or remains "creditable." Prescription drug discount cards, free clinics, drug samples or drug discount websites do not constitute creditable prescription drug coverage.

National Average Part D Premium

The average Part D premium is published in the *Medicare & You* handbook each year. This handbook is mailed to all Medicare beneficiaries each year and can also be downloaded from Medicare.gov. LEPs are recalculated each year based on the national average premium for that contract year. Plan Sponsors are responsible for reviewing CMS' enrollment systems to determine whether an enrollee had any gaps in Part D coverage and whether the enrollee had creditable prescription drug coverage during the gaps. This determination is included with the submission of the enrollment request to CMS. CMS calculates the LEP and advises the Plan Sponsor of the additional charge that needs to be added to the member's monthly premium.

Calculating a Late Enrollment Penalty

CMS is the only entity authorized to calculate a beneficiary's LEP amount. Care must be exercised when explaining the LEP policy so that a beneficiary understands that CMS calculates and determines final penalty amounts.

The examples below illustrate basic calculations of the LEP but there are other factors that could affect it. A beneficiary qualifying for a LIS or providing proof of creditable prescription drug coverage will affect the calculation of the LEP. Beneficiaries who were eligible for LIS at the time of enrollment will not be assessed an LEP when they enroll.

LEP is calculated using the national base beneficiary premium amount. That amount is $34.10 in 2017 and may change for 2018. Information provided here was accurate as of the release date of this guide but is subject to change each year.

Example 1

Bob turned 65 on April 13, 2016, but chose not to enroll in Part D coverage during his initial enrollment period (the seven months surrounding his 65th birthday) which ended July 31, 2016. He enrolled in a Medicare Part D plan during the annual enrollment period (AEP) with coverage effective January 1, 2017. The enrollment review showed he did not have any prescription drug coverage from August 1, 2016, through December 31, 2016 – a five month period. His estimated LEP, based on the published 2017 national average, was an additional $1.71 (5 months x $.3410) each month, or $1.70 when rounded to the nearest 10 cents.

Example 2

Mrs. Johnson is currently eligible for Medicare and was eligible to join a Medicare prescription drug plan by February 1, 2016. She did not join and does not have any other prescription drug coverage. She chooses to enroll in Part D during the AEP from October 15 – December 7, 2016.

Mrs. Johnson's Part D coverage effective date is January 1, 2017. Since she was without creditable drug coverage from February 1, 2016, through December 31, 2016, her penalty will be 1% of the LEP for 2017 times the number of months she did not have coverage. For 2017, 1% of the national average LEP is $.3410 (1% x $34.10) – the LEP amount released by Medicare times 11 or (11 x $.3410). LEPs are rounded to the nearest 10 cents so her LEP is $3.80. This LEP amount is added to her monthly premium beginning January 1, 2017.

Employer or union group Medicare plans may pay all or a portion of the LEP for its retirees. If an employer or union Plan Sponsors prescription drug coverage for its members though the Part D plan, the Part D Plan Sponsor will bill the employer or union directly for any LEP if both the Part D Plan Sponsor and the employer or union agree.

General Enrollment Guidelines Related to LEP

Beneficiaries should be made aware that having creditable prescription drug benefits does not create a Part D enrollment opportunity; it may only eliminate or reduce the LEP. Enrollment periods as described in Section 4 and the CMS Medicare Managed Care Manual still apply regardless of whether creditable prescription drug coverage was in effect.

For more information, contact your local plan for assistance in determining possible LEPs. Tell beneficiaries that you can offer an estimate based on the examples above, but advise them that CMS calculates and determines their final penalty amount.

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

In 2011, Medicare Part D enrollees began paying income-related premium adjustment amounts to Medicare, called the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). This is a premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. Social Security determines which beneficiaries have to pay the higher amounts and notifies affected members. The income-related amounts Part D members will pay are listed in Section 1, Eligibility and Enrollment Periods. This amount is in addition to any late enrollment penalty that may apply.

Summary

- Extra help is available for people who qualify for full Medicaid benefits, receive Supplemental Security Income, are enrolled in a Medicare Savings Program, or meet certain income and resource limits.

- Low income subsidy (LIS) beneficiaries will be offered benefits that replace those of their chosen Part D plan. LIS members use the plan's formulary and pharmacy network.

- CMS requires that all PDP sponsors offering group plans ensure any LIS amount paid on behalf of a LIS beneficiary accrues first to the benefit of the LIS-eligible beneficiary.

- Eligible beneficiaries not electing Part D coverage when first eligible and who are determined to have been without creditable prescription drug coverage for a continuous period of 63 days or more may be assessed a late enrollment penalty (LEP) upon enrollment in a Part D plan.

- The LEP is calculated as 1% of the national average premium for Part D plans in the year in which the beneficiary is enrolling. This is then multiplied by the number of months during which the enrollee is identified as not having had creditable prescription drug coverage.

- Employer or union group Medicare plans may pay all or a portion of the LEP for its retirees.

- Beneficiaries should be made aware that having creditable prescription drug benefits does not create a Part D enrollment opportunity; it may only eliminate or reduce the LEP.

6. MedicareBlue Rx Overview

Table of Contents

Introduction

Learning Objectives

At the end of this section you will be able to:

- Describe the two MedicareBlue Rx plan options – Standard and Premier
- Name the MedicareBlue Rx formulary drug tiers
- Understand the MedicareBlue Rx pharmacy network, including pharmacies that offer preferred cost sharing and pharmacies that offer standard cost sharing
- Understand how low income subsidy (LIS) assistance and the late enrollment penalty (LEP) apply to MedicareBlue Rx plans

The Blue Cross Blue Shield Northern Plains Alliance (NPA) was formed in 2005 to contract with CMS. The NPA provides regional Medicare prescription drug coverage in the seven-state Part D Region 25 through seven separate Blue Cross and Blue Shield plans:

- Wellmark Blue Cross and Blue Shield of Iowa*
- Blue Cross and Blue Shield of Minnesota*
- Blue Cross and Blue Shield of Montana*
- Blue Cross and Blue Shield of Nebraska*
- Blue Cross Blue Shield of North Dakota*
- Wellmark Blue Cross and Blue Shield of South Dakota*
- Blue Cross Blue Shield of Wyoming*

*Each plan is an independent licensee of the Blue Cross and Blue Shield Association.

MedicareBlue Rx

MedicareBlue Rx is a stand-alone Prescription Drug Plan (PDP) available to all Medicare beneficiaries residing in the seven-state region. The plan offers two options with different levels of coverage.

Pharmacy Network

Although most members will purchase drugs within the plan's service area, members may also purchase prescription drugs at any of the more than 67,000 network pharmacies across the United States. The reimbursement rates for network pharmacies are negotiated in advance as part of the pharmacy's contract with the plan. All claims are processed in real time electronically when the member purchases a prescription. This lets the member know immediately the amount to pay, and whether it is a copay or coinsurance.

Prescription drugs are not covered outside the United States and its territories, even in emergency or urgent care situations. Prescriptions purchased outside the U.S., such as in Canada or Mexico, cannot be submitted to MedicareBlue Rx for reimbursement and will not be considered when calculating a member's "True Out-of-Pocket" (TrOOP) costs for Catastrophic Coverage benefits.

Members may use out-of-network pharmacies in the U.S. to fill a prescription in certain situations if they are unable to locate a network pharmacy in the area:

- For medical emergencies, if the prescription is related to care for the medical emergency or urgently needed care
- If the member becomes ill, loses or runs out of a prescription drug when traveling or away from the plan's service area
- Member cannot obtain a covered drug in a timely manner within the service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service
- The covered drug is not regularly stocked at an accessible network retail or mail order pharmacy

The member is responsible for paying the full cost of the prescription at the time of purchase at the out-of-network pharmacy. The member must submit a paper claim to be reimbursed for the plan's share of the cost. The member will be required to pay any difference between what the plan would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for the prescription.

Pharmacies with Preferred Cost Sharing

Within the participating pharmacy network, there are some pharmacies that offer preferred cost sharing. The plan has negotiated lower cost-sharing amounts for prescription drugs at these pharmacies. That means members will often pay less for prescription drugs when they fill them at a pharmacy that offers preferred cost sharing. Members can go to a pharmacy that offers standard cost sharing, which is still a network pharmacy, but they will often pay more for their prescription drugs.

- Pharmacies with preferred cost sharing: More than 1,600 in the 7-state region and more than 36,000 nationwide, including CVS/pharmacy (and CVS locations in Target), Hy-Vee, Shopko, Wal-Mart and White Drug
- Pharmacies with standard cost sharing: All other network pharmacies

Members who do not live near a pharmacy that offers preferred cost sharing can take advantage of the preferred pricing by filling prescriptions through the plan's mail order service (see 90-Day Extended Supplies, next).

90-Day Extended Supplies

Members who need ongoing supplies of "maintenance" prescriptions, such as drugs used to treat hypertension or cholesterol, can save time and money by obtaining a 90-day extended supply. Members have two ways to get an extended supply:

- Through CVS Caremark* Mail Order Pharmacy, the plan's mail order pharmacy program. The cost for a 90-day supply through mail order for members of both plan options is two times the monthly copay, or the usual coinsurance percentage. Members can take advantage of CVS Caremark's optional ReadyFill at Mail® automatic prescription refill and renewal service if they wish. Note: Certain specialty drugs are not available by mail and are identified in the formularies with an "NM" for not available through mail order.
- At all network retail pharmacies that have agreed to offer extended supplies. These pharmacies are identified in the pharmacy directory as extended day supply pharmacies with the letters "EDS." The cost for a 90-day supply from an EDS pharmacy for members of both plan options is two times the monthly copay, or the usual coinsurance percentage.

*CVS Caremark Part D Services is an independent company providing pharmacy benefit management services.

Extended supply pharmacies are also identified when searching for a pharmacy at YourMedicareSolutions.com. CVS Caremark Mail Order Pharmacy information and forms are included in members' welcome packets and can be found in the pharmacy directory. This information can also be ordered through Customer Service or found online at YourMedicareSolutions.com.

Extended supplies may not be available if:

- The member is utilizing out-of-network pharmacies for the situations described previously; when using out-of-network pharmacies, they can only purchase a 30-day supply of the covered medication.
- The prescription drug is subject to a quantity limit or prior authorization, in which case a 90-day supply may not be allowed. The member will need to contact his or her doctor or Customer Service to see if a 90-day supply is possible.

For more information, review the MedicareBlue Rx Summary of Benefits or Evidence of Coverage, the Pharmacy Directory, the Formulary or contact your local Blue Cross and Blue Shield plan.

Formulary

A formulary is a list of covered drugs selected by the plan in consultation with a team of health care providers that includes doctors and pharmacists. The formulary represents the prescription therapies believed to be a necessary part of a quality treatment program. The formularies for the two MedicareBlue Rx plan options are different, but both have five tiers of drugs:

- Tier 1: Preferred Generic – Lowest tier and includes some preferred brands
- Tier 2: Generic – includes generic and some low-cost preferred brands
- Tier 3: Preferred Brand – preferred brand drugs and non-preferred generic drugs
- Tier 4: Non-Preferred Drug – non-preferred brand drugs and non-preferred generic drugs
- Tier 5: Specialty Tier – very high cost brand and some generic drugs, which may require special handling and/or close monitoring

Formularies may change during the year as new drugs are approved and added, others are withdrawn or as drugs move to a different coverage tier. The latter often happens if a generic form of the drug becomes available. If a member's drug is not on the formulary, he or she can ask for a list of similar drugs that are covered and talk to his or her doctor to see if an alternative would be effective. The member and his or her doctor may also submit an exception request to have the drug covered. Such requests are not guaranteed to be approved.

Certain drugs are not included in the formulary and will not be covered by the plan because they do not meet the definition of a Part D drug under CMS regulations. These drugs are referred to as "Part D Excluded Drugs." Examples of these types of drugs are erectile dysfunction drugs, barbiturates not used for treatment of epilepsy, cancer or a chronic mental disorder, drugs used for cosmetic purposes and certain allergy or cold medications.

In 2011, drug manufacturers began offering 50 percent discounts on brand-name drugs in the coverage gap due to provisions in the Affordable Care Act. Most drug manufacturers have signed agreements with CMS. CMS has required Plan Sponsors to remove brand-name drugs not covered by an agreement from their formularies. These drugs are no longer covered Part D drugs. For the most up-to-date list of drugs on MedicareBlue Rx's formulary, refer to YourMedicareSolutions.com.

Utilization Management

Some formulary prescription drugs have additional requirements for coverage or limits on coverage. These limits and requirements are generally referred to as utilization management. Utilization management may include step therapy, quantity limits or prior authorization. Drugs that have these requirements are identified in the formulary.

Step Therapy
Step therapy means the member must try other safe, similar and more cost-effective drugs before a certain higher-cost drug will be covered. This could involve trying a generic or a preferred brand drug as step one and moving to others for step two. If the alternative drugs do not produce

the desired result or the member has an adverse reaction to the step therapy drugs, the member may be able to obtain coverage for the prescribed drug.

Quantity Limits
MedicareBlue Rx covers a 30-day supply for retail prescriptions (90-day supply for extended supplies). Quantity limits ensure the medication is being used correctly and other treatments are not more appropriate. Most members would not need to take these drugs more often than what is allowed. An example of this could be a drug that is only taken once a week. In this instance, the prescription would be limited to four units – a one-month supply. No special steps are necessary by the physician or member as long as the medications are prescribed within the limitations. If a member requires a larger quantity than is allowed, the physician will need to request an exception to have the larger quantity covered.

Prior Authorization
Prior authorization is required for certain covered drugs that have been approved by the Food and Drug Administration (FDA) for specific medical conditions. The member's physician must complete the prior authorization form and fax it to the plan for review. On the form the physician can describe the member's medical condition that requires the use of drugs that appear on the prior authorization list. Physicians can do this in advance to prevent the member from experiencing delays at the pharmacy.

Exception Requests
If a member wants the plan to make an exception to the coverage rules or formulary, he or she may request an exception. There are several types of exceptions the member could ask for:

- That the plan cover the drug even if it is not on the formulary.
- That the plan waive coverage restrictions or limits for a drug, such as the quantity limit for a particular drug.
- Changing coverage of a drug to a lower cost-sharing tier. Every drug on the Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less the member will pay as their share of the cost of the drug.
    - If a drug is in Tier 2 (Generic) the member can ask the plan to cover it at the cost-sharing amount that applies to drugs in Tier 1 (Preferred Generic). This would lower your share of the cost for the drug.
    - If a drug is in Tier 3 (Preferred Brand), the member can ask the plan to cover it at the cost-sharing amount that applies to drugs in Tier 2 (Generic). This would lower your share of the cost for the drug.
    - If a drug is in Tier 4 (Non-Preferred Brand) the member can ask the plan to cover it at the cost-sharing amount that applies to drugs in Tier 3 (Preferred Brand). This would lower your share of the cost for the drug.
    - A beneficiary cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Tier)

If a member's request to cover a drug that is not on the formulary is granted, the member cannot ask for a higher tier of coverage for the drug. Part D Excluded Drugs are never eligible for exception requests.

MedicareBlue Rx Plan Options

MedicareBlue Rx offers two coverage options. Both options offer solid coverage and protect members against the high cost of drugs. The cost sharing shown in the charts on this page and the next is for a 30-day retail supply.

MedicareBlue Rx Standard

This option is a basic prescription drug plan that offers members different cost sharing at preferred pharmacies and standard pharmacies. Its premium is $35.10 per month in 2017. There is no annual deductible on Tier 1 and a $400 annual deductible on Tiers 2 through 5. When a member purchases prescription drugs from Tier 1 of the formulary, the plan and the member begin cost sharing right away since there is no annual deductible for Tier 1. For drugs purchased from Tiers 2 through 5, the member must first spend $400 before cost sharing begins.

<table>
<tr><th rowspan="2">Annual Deductible Member Pays:</th><th rowspan="2">Drug Tier:</th><th colspan="2">Initial Coverage Member Pays:</th><th rowspan="2">Coverage Gap Member Pays:</th><th rowspan="2">Catastrophic Coverage Member Pays:</th></tr>
<tr><th>Preferred Cost Sharing</th><th>Standard Cost Sharing</th></tr>
<tr><td rowspan="5">$0 for Tier 1; $400 for Tiers 2-5</td><td>Tier 1: Preferred Generic drugs</td><td>$1 copay</td><td>$13 copay</td><td rowspan="5">No more than 40% of the plan’s costs for brand-name drugs and 51% of the plan’s costs for generic drugs</td><td rowspan="5">The greater of:
▪ 5% coinsurance, OR
▪ $3.30 copay for generics and $8.25 copay for all other drugs</td></tr>
<tr><td>Tier 2: Generic</td><td>$6 copay</td><td>$19 copay</td></tr>
<tr><td>Tier 3: Preferred Brand drugs</td><td>18% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4: Non-Preferred Drug</td><td>35% coinsurance</td><td>50% coinsurance</td></tr>
<tr><td>Tier 5: Specialty Tier</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td colspan="4">When total prescription drug costs reach $3,700, members reach the coverage gap. ⟶</td><td colspan="2"></td></tr>
<tr><td colspan="5">When total out-of-pocket costs reach $4,950, members reach catastrophic coverage benefits. ⟶</td><td></td></tr>
</table>

MedicareBlue Rx Premier

This option offers more coverage and has a higher premium of $92.00 per month in 2017. There is no deductible so the plan and member begin cost sharing with the member's first prescription from any drug tier. This option covers Tier 1 (Preferred Generic) in the coverage gap for a $0 or $15 copay and Tier 2 (Generic) in the coverage gap for a $0 or $20 copay.

<table>
<tr><th rowspan="2">Annual Deductible Member Pays:</th><th rowspan="2">Drug Tier:</th><th colspan="2">Initial Coverage Member Pays:</th><th rowspan="2">Coverage Gap Member Pays:</th><th rowspan="2">Catastrophic Coverage Member Pays:</th></tr>
<tr><th>Preferred Cost Sharing</th><th>Standard Cost Sharing</th></tr>
<tr><td rowspan="5">$0</td><td>Tier 1: Preferred Generic</td><td>$0 copay</td><td>$15 copay</td><td rowspan="5">$0/$15 copay for Tier 1: Preferred Generic;
$0/$20 copay for Tier 2: Generic;
no more than 40% of the plan's costs for brand-name drugs and 51% of the plan's costs for generic drugs</td><td rowspan="5">The greater of:
▪ 5% coinsurance, OR
▪ $3.30 copay for generic and $8.25 copay for all other drugs</td></tr>
<tr><td>Tier 2: Generic</td><td>$0 copay</td><td>$20 copay</td></tr>
<tr><td>Tier 3: Preferred Brand</td><td>18% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 4: Non-Preferred Drug</td><td>45% coinsurance</td><td>50% coinsurance</td></tr>
<tr><td>Tier 5: Specialty Tier</td><td>33% coinsurance</td><td>33% coinsurance</td></tr>
<tr><td></td><td colspan="3">When total prescription drug costs reach $3,700, members reach the coverage gap. →</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="4">When total out-of-pocket costs reach $4,950, members reach catastrophic coverage benefits. →</td><td></td></tr>
</table>

Medication Therapy Management (MTM) Program

MedicareBlue Rx's Medication Therapy Management (MTM) program is designed to make sure the drugs beneficiaries take are safe and effective for their conditions. By working with beneficiaries to review their medications, the program may help them achieve better health by avoiding harmful drug interactions and improving their understanding and use of their medications.

MTM program services are part of a beneficiary's prescription drug plan coverage and are offered at no additional cost to the beneficiary. Participating is easy. If eligible, beneficiaries are automatically enrolled and will receive a letter and brochure explaining the program. They can opt out, but are encouraged to take advantage of the services offered to get the most out of their plan. Beneficiaries may be eligible if they have at least three chronic medical conditions, take at least eight prescription drugs and have high drug costs.

Here's how it works. If a beneficiary agrees to participate, a nurse or pharmacist will call him or her to do a Comprehensive Medication Review (CMR). He or she will:

- Review all medications the beneficiary takes, including prescriptions, over-the-counter medications, herbal therapies and dietary supplements
- Create a list of the beneficiary's medications
- Explain how the medications work and their side effects
- Answer questions or concerns the beneficiary has about his or her medications

The beneficiary will then be mailed a personalized list of medications and a summary of any concerns discussed during the call. He or she may also receive helpful information about his or her health conditions. Beneficiaries are encouraged to bring their CMR information to their annual wellness exam and any other doctor visit.

In addition to the CMR, the MTM program also includes automatic, targeted communications to members about their specific disease states. For more information about the MTM program, contact Customer Service.

Low Income Subsidy (LIS)

Low income subsidy (LIS) members may be eligible for reduced premiums, deductibles, coinsurance and/or copays under MedicareBlue Rx. CMS will notify MedicareBlue Rx of an individual's LIS status during the accretion process and will apply the subsidy accordingly to both the plan premium and the Part D benefits upon final enrollment approval. For more information on LIS, please see Section 5, Low Income Subsidy and the Late Enrollment Penalty.

Late Enrollment Penalty (LEP)

The late enrollment penalty (LEP) may apply to beneficiaries who were without creditable prescription drug coverage and who did not enroll in Medicare Part D prescription drug coverage when first eligible. The penalty is added to the member's total MedicareBlue Rx premium cost. CMS determines the penalty during the accretion process and notifies the Plan Sponsor of the penalty amount to be applied to the premium. For more information on the LEP, please see Section 5, Low Income Subsidy and the Late Enrollment Penalty.

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

In 2011, Medicare Part D enrollees began paying income-related premium adjustment amounts to Medicare, called the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). This is a premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. Social Security determines which beneficiaries have to pay the higher amounts and notifies affected members. This amount is in addition to any late enrollment penalty that may apply. For more information on Part D-IRMAA, including the income-related amounts Medicare Parts A-D members will pay, please see Section 1, Eligibility and Enrollment Periods.

MedicareBlue Values and Discounts

The MedicareBlue Values program is designed to save members time and make it easier for them to take an active role in their overall well-being. MedicareBlue Rx members are automatically enrolled at no additional cost in programs that include access to discounts on:

- Vision exams, eyewear and laser surgery
- Hearing exams and hearing aids
- CVS brand health care products purchased at CVS/pharmacy locations

Members can access the vision and hearing discounts by showing their member ID card or simply telling the provider they are a Blue Cross and Blue Shield member. Members can access the discounts as often as they like and there are no claim forms to complete. The member's discount, if available, is applied immediately when the member makes a purchase.

Vision discounts

- Eyewear and contact lens discounts are available through Davis Vision. Members can access Davis Vision online at davisvision.com.
- Members have access to a network of ophthalmologists and optometrists.
- Receive a discount on contact lenses and LASIK procedures through TruVision. Members can access TruVision online at truvision.com.

Hearing discounts

- Beltone's hearing discount includes 25% savings on eligible products and services. The price for hearing aids includes the hearing screening, exam and fitting. A one-year supply of batteries is free with hearing aid purchase. Members can access Beltone online at beltone.com.
- TruHearing's discount includes up to 50% savings on TruHearing Basic, Medallion and Ultra hearing aids. Other benefits include a two-year warranty, 45-day money back guarantee, a free hearing screening, two additional free visits to a hearing professional and one-year interest-free member financing (with approved credit). Members can access TruHearing online at truhearing.com.

CVS Caremark* ExtraCare® Health Card

Within six weeks following the member's effective date, members will receive an ExtraCare® Health card that can be used to receive a 20% discount on regular priced CVS brand health care products purchased at any CVS/pharmacy location or online at cvs.com. The discount applies to health-related items valued at $1 or more, such as cough and cold remedies, nonprescription allergy and pain relief medications, vitamins, first aid supplies, skin care products, eye care products and diabetes testing supplies.

The card includes all the benefits of a CVS ExtraCare Card, including special weekly sales and the opportunity to earn ExtraBucks® on purchases and prescriptions. Members are not obligated to fill prescriptions at a CVS/pharmacy in order to use their ExtraCare® Health card.

Members will receive two key tags that can be used by any family member. The key tag must be presented at the time of purchase to receive the discount.

The ExtraCare Health card is not a plan benefit, but a no-cost, value-added program. There is no limit on how often a person can use their ExtraCare Health card.

**CVS Caremark Part D Services is an independent company providing pharmacy benefit management services.*

Note: The items discussed in this section, MedicareBlue Values and Discounts, are considered value-added items and services (VAIS). VAIS are items and services that are not plan benefits, are not part of the Plans'/Part D Sponsor's benefit package and may not be marketed to prospective enrollees, or used as an inducement or incentive for enrollment. VAIS are non-Medicare covered services or items, typically discounts, offered by a VAIS provider to the enrollees of an MA plan.

VAIS information cannot be included in or bound with materials intended for prospective enrollees, or posted on parts of the website directed at prospective enrollees.

Summary

- 2017 MedicareBlue Rx overview:

	MedicareBlue Rx Standard		MedicareBlue Rx Premier	
	Preferred Cost Sharing	**Standard Cost Sharing**	**Preferred Cost Sharing**	**Standard Cost Sharing**
Premiums (monthly)	$35.10		$92.00	
Annual Deductible	$0 for Tier 1; $400 for Tiers 2-5		$0	
Initial coverage – retail pharmacy (30-day supply)				
Tier 1: Preferred Generic	$1 copay	$13 copay	$0 copay	$15 copay
Tier 2: Generic	$6 copay	$19 copay	$0 copay	$20 copay
Tier 3: Preferred Brand	18% coinsurance	25% coinsurance	18% coinsurance	25% coinsurance
Tier 4: Non-Preferred Drug	35% coinsurance	50% coinsurance	45% coinsurance	50% coinsurance
Tier 5: Specialty Tier	25% coinsurance	25% coinsurance	33% coinsurance	33% coinsurance
Coverage gap – amount members pay for a 30-day supply after total yearly covered prescription drug costs reach $3,700	40% of the plan's costs for brand-name drugs and 51% of the plan's costs for generic drugs		$0/$15 copay for Tier 1: Preferred Generic; $0/$20 copay for Tier 2: Generic; members pay 40% of the plan's costs for brand-name drugs and 51% of the plan's costs for other generic drugs	
Catastrophic coverage – amount members pay for a 30-day supply after they have paid $4,950 in out-of-pocket prescription drug costs	The greater of: • 5% coinsurance, OR • $3.30 copay for generic (including brand drugs treated as generic) and $8.25 copay for all other drugs			

- MedicareBlue Rx is offered by seven Blue Cross and Blue Shield plans in the Northern Plains Alliance across a seven-state region.

- MedicareBlue Rx plan options include a nationwide network of more than 67,000 pharmacies and a prescription drug formulary to help control health care costs for members.

- Within the participating network, there are some pharmacies that offer preferred cost sharing. Members often pay lower copays and coinsurance when they fill prescriptions at these pharmacies. Members can go to a pharmacy that offers standard cost sharing, which is still a network pharmacy, but they will often pay more.
    - Pharmacies with preferred cost sharing: More than 1,600 in the 7-state region and more than 36,000 nationwide, including CVS/pharmacy (and CVS locations in Target), Hy-Vee, Shopko, Wal-Mart and White Drug
    - Pharmacies with standard cost sharing: All other network pharmacies

- There are two different formularies for MedicareBlue Rx, but both have five tiers of drugs.

- MedicareBlue Rx may not be suitable for individuals enrolled in employer group or union benefits or other types of creditable prescription drug coverage. Beneficiaries should be encouraged to evaluate their current coverage to make an appropriate enrollment decision.

- Members eligible for low income subsidy (LIS) assistance will have those benefits applied to MedicareBlue Rx coverage. They pay the difference between the premium for MedicareBlue Rx and the amount of their subsidy.

- Members required to pay a late enrollment penalty (LEP) will have the LEP added to their MedicareBlue Rx monthly premium.

- Once enrolled, members of MedicareBlue Rx can take advantage of a variety of discount programs, including discounts on eyewear, hearing aids and other health-related items. However, these programs may not be marketed to prospective enrollees, or used as an inducement or incentive for enrollment.

Glossary

A

Abuse – includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Advertising – materials intended to attract or appeal to Medicare beneficiaries and influence them to call for detailed information on the product being advertised. These materials are intended to be quickly read and do not contain the level of detail expected in other marketing materials. Examples of advertising include radio ads, newspaper ads, outdoor advertising, event signage, internet advertising, pharmacists' promotional buttons, window stickers, counter tents and some direct mail (such as postcards, self-mailers and reply cards).

Annual Enrollment Period (AEP) – this is the time of year when Medicare beneficiaries can enroll in, disenroll from or switch MA, MA-PD or PDP plans. The Annual Enrollment Period is from October 15 through December 7 each year. Coverage changes are effective on January 1.

Appeal – a special kind of complaint members make if they disagree with certain kinds of decisions made by Medicare or their health or prescription drug plan. They can appeal if they request coverage for a health care service, supply or prescription that they think they should be able to get, or request payment for health care already received, and Medicare or a plan denies the request. They can also appeal if they are already receiving coverage and the plan stops paying. There are specific processes that both the member and the plan must use for appeals.

Application date – the date an enrollment request is received by the plan. This includes the date it is received by a sales person. A sales person signature and signature date and/or an agency date stamp may be required by the Plan Sponsor in order to confirm the application date.

Authorized representative – the person authorized to act on behalf of the individual under the laws of the state where the individual resides. When an authorized representative signs an enrollment form, it certifies that 1) this person is authorized under state law to complete the enrollment and 2) documentation of this authority is available upon request by MedicareBlue Rx or Medicare.

B

Beneficiary – the name for a person who has health care insurance through the Medicare or Medicaid program.

Benefit period – a benefit period as defined by Medicare begins on the first day of an inpatient hospital stay and ends when the beneficiary has been out of the hospital or skilled nursing facility for at least 60 days in a row. If a beneficiary is discharged and then readmitted to a hospital or skilled nursing facility within 60 days, the previous benefit period continues. If the beneficiary goes into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. A beneficiary must pay the Part A inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Brand-Name drugs – these drugs are usually produced by a single manufacturer that holds the patent on the drug and manufactures it with a product name under which the drug is advertised and sold. (For example, Tylenol® is a brand-name for acetaminophen.) Brand-name drugs are typically more expensive drugs.

C

Catastrophic coverage – coverage that applies when a member has very high drug costs. For all Medicare prescription drug plans, it begins after a member has paid $4,950 (in 2017) out-of-pocket for covered drugs in a calendar year. Once this out-of-pocket level is reached, the member pays the greater of 5% of the cost for each covered prescription or a small copay until the end of the calendar year.

The Centers for Medicare & Medicaid Services (CMS) – the federal agency that oversees the Medicare program. In addition, CMS works with the states to oversee Medicaid programs and Medicare health plans. CMS makes sure that beneficiaries eligible for these programs are able to get access to high-quality health care.

Chain pharmacy – one of a group of pharmacies, usually three or more, under the same management and/or ownership. Chains are often national, such as CVS/pharmacy, (including CVS locations in Target), Walgreens or Wal-Mart.

Claim(s) – requests for payment submitted by providers or members for covered services.

Coinsurance – the percentage of the cost that a member pays for an eligible service, supply or drug after paying any applicable plan deductible.

Copayment or Copay – the set dollar amount a member pays to receive a specific service or prescription drug. The plan pays the remaining cost. Copays vary depending on the plan and the services received.

Cost sharing – a copay, coinsurance or deductible a member pays under a particular benefit plan.

Coverage gap (often referred to as the "donut hole") – once a member's total yearly covered prescription drug costs under a Medicare Part D plan reach $3,700 (in 2017), the member reaches the coverage gap and pays 51% of the plan's costs for generic drugs and no more than 40% of the plan's costs for brand-name drugs until total out-of-pocket drug costs reach $4,950 (in 2017).

Creditable coverage – certain kinds of previous health insurance coverage that may allow the member to shorten or eliminate a pre-existing condition waiting period under a Medigap policy. (See Pre-existing conditions.) Note: This is not the same as "creditable prescription drug coverage."

Creditable prescription drug coverage – prescription drug coverage (for example, from an employer or union group) that is expected to pay, on average, at least as much as Medicare's standard prescription drug benefit. If a beneficiary currently has prescription drug coverage that is considered "creditable prescription drug coverage" he or she may keep that coverage and wait to enroll in a Part D plan. If he or she later decides to enroll in a Part D plan, a late enrollment penalty will not apply.

D

Deductible – amount a member may have to pay for eligible covered health care services or prescription drugs before the plan begins providing benefits.

Dose/Dosage – a unit measurement of medication. A measured quantity to be taken or administered at one time.

Drug tier – the tier or benefit level a drug is covered under in a formulary. Preferred Generic, Generic, Preferred Brand, Non-Preferred Drug and Specialty Tier are drug tiers.

Dual eligibility – individuals with full Medicaid, Supplemental Security Income (SSI) or Medicare Savings Program benefits ***and*** Medicare benefits are considered to be "dually-eligible." They are automatically identified by CMS as eligible for low income subsidies for Part D prescription drug coverage.

E

Education – informing a potential enrollee about Medicare Advantage or other Medicare programs, but not steering or attempting to steer a potential enrollee toward a specific plan or limited number of plans. The individual assisting the potential enrollee cannot receive compensation directly or indirectly from the plan for this assistance.

Exception request – a formulary exception request is a request to allow coverage for a prescription drug that is not on the plan's formulary. A tiering exception is a decision to charge the member a lower tier amount for a drug that is on a higher drug tier. Another exception can be a decision not to apply a limit, like a dose or quantity limit. The member's doctor must send an exception request form on behalf of the member and include supporting documentation with the medical reason for the exception request. Approval of exception requests is not guaranteed.

Excluded drugs – certain types of drugs or categories of drugs that by law cannot be covered by Medicare Prescription Drug plans. In addition, a Medicare Prescription Drug plan cannot cover a drug that is covered under Medicare Part A or Part B.

Exclusions – specific conditions or circumstances listed in the member contract or Evidence of Coverage for which the policy or plan will not provide benefits.

Extended Day Supply (EDS) pharmacy – a network pharmacy that provides an extended supply (90-day) of a prescription drug, often at mail order rates.

F

Food and Drug Administration (FDA) – a Federal agency within the Department of Health and Human Services (HHS). The FDA reviews the results of laboratory, animal and human clinical testing done by companies to determine if a product (such as a new drug) is safe and effective. Once products are on the market, the FDA keeps track of how they are manufactured and responds to reports of problems or newly identified risks.

Formulary – a list of prescription medications that are approved for coverage by a health plan and that will be dispensed through contracted pharmacies. The health plan works with a group of medical professionals including doctors and pharmacists to develop the formulary. This list may change during the year.

Formulary exception – see Exception request.

Formulary tiers/levels – see Drug tier.

Fraud – knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

G

General Enrollment Period (GEP) – annual enrollment period for eligible beneficiaries to enroll in Part B benefits if they did not previously do so. The GEP is from January 1 through March 31 each year. Coverage for those who enroll during the GEP is effective July 1 and a penalty will be applied to the Part B premium, unless an exception applies.

Generic –the Generic drug tier includes generic drugs and some low-cost preferred brand-name drugs. Drugs in this formulary tier are less commonly prescribed drugs used to treat a condition (as compared to drugs in the Preferred Generic drugs formulary tier).

Guaranteed issue rights (also called "Medigap Protections") – rights a beneficiary has in certain situations when insurance companies are required by law to offer a Medigap policy to the beneficiary. In these situations, an insurance company can't deny coverage, or place conditions on coverage, such as exclusions for pre-existing conditions, and can't charge more for coverage because of past or current health conditions.

Guaranteed renewable – a right a member has that requires an insurance company to automatically renew or continue a Medigap policy, unless the member made untrue statements to the insurance company, committed fraud or did not pay the premium. Required for all Medigap policies issued since 1992.

H

Health Insurance Portability and Accountability Act (HIPAA) – passed in 1996, HIPAA outlines privacy and security regulations for individually identifiable health information. The final regulations became effective in April 2003, with small health plans given an additional year to comply.

Health maintenance organization (HMO) plan – a type of Medicare Advantage plan available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, members must choose a primary care clinic or provider and request referrals for services outside this primary provider except in an emergency. Costs may be lower than in the Original Medicare program.

Health Plan Management System (HPMS) marketing module – Plans/Part D Sponsors must submit marketing materials for review through the HPMS Marketing Module, which is an automated tool used to enter, track and maintain materials submitted to CMS for review and approval. The HPMS Marketing Module User Guide provides extensive information on how to use HPMS. Plans/Part D Sponsors should refer to the User Guide for any questions regarding the Marketing Module or how to submit materials in HPMS.

Home infusion pharmacy – a participating network pharmacy specializing in supplying members with home infusion therapy medications and supplies.

I

Identification card (ID card) – a member's health plan card with membership information that identifies the member as enrolled in a health and/or prescription drug plan.

Initial Enrollment Period (IEP) – a seven-month period that begins three months before a person first becomes eligible for Medicare (for most people this is the month of their 65th birthday), includes the month of eligibility and continues for the three months after the month of eligibility. The IEP may relate to enrollment in Original Medicare benefits and Part D benefits.

In-network – description of a provider that is participating in the plan's network. Services received from in-network providers generally leave the member with less cost sharing for covered services.

I/T/U – I/T/U refers to a type of pharmacy and is an abbreviation for "Indian Health Service, Tribal and Urban Indian Health Program" pharmacy.

J/K

L

Late enrollment penalty (LEP) – the penalty assessed when a beneficiary did not enroll in Medicare prescription drug coverage when first eligible and was not enrolled in creditable prescription drug coverage for a period of 63 days or more from the end of the IEP. The penalty is 1% of the national average Part D premium multiplied by the number of months the beneficiary was not enrolled in creditable prescription drug coverage.

Lifetime reserve days – in the Original Medicare plan, 60 days that Medicare Part A will pay for when a beneficiary is in a hospital more than 90 days within a benefit period. These 60 days can be used only once during a beneficiary's lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily copay.

Long-term care – a variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for custodial care if this is the only kind of care needed.

Long-term care pharmacy – a participating network pharmacy located in or serving a long-term care facility.

Low income subsidy (LIS) – extra help available for qualifying beneficiaries to help pay the cost of Part D plan premiums and drug costs. This extra help is available for people who meet specific income and resource limits or qualify as dually-eligible. The amount of low income subsidy available to the beneficiary is determined by the Social Security Administration (SSA).

M

Mail order pharmacy – a non-retail pharmacy offering home and/or office delivery of medications via mail or express carrier. The medications are those usually taken as maintenance drugs.

Maintenance drug – a prescription drug prescribed for an ongoing condition, such as diabetes, arthritis, high blood pressure or heart conditions.

Marketing – CMS defines marketing as steering or attempting to steer a potential enrollee towards a plan, or limited number of plans or promoting a plan or limited number of plans. Educational events do not constitute marketing.

Marketing materials – CMS defines marketing materials as any materials targeted to Medicare beneficiaries which:

- Promote the Plan Sponsor, or any Plan Sponsor offered by the MA organization
- Inform Medicare beneficiaries that they may enroll, or remain enrolled in, a Plan Sponsor offered by the MA organization
- Explain the benefits of enrollment in a Plan Sponsor, or rules that apply to enrollees
- Explain how Medicare services are covered under a Plan Sponsor, including conditions that apply to such coverage

Marketing materials exclude ad hoc enrollee communications materials.

The definition of marketing materials for Medicare programs extends beyond advertising materials to include notification forms and letters used to enroll, disenroll and communicate with members regarding many different membership scenarios. The Internet is considered another vehicle for the distribution of marketing information. CMS marketing review authority extends to all marketing activity (i.e., advertising, pre-enrollment and post-enrollment activities) via the Internet.

Medicaid – a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, and the costs are shared between the federal and state governments.

Medical underwriting – the process that an insurance company uses to decide, based on a person's medical history, whether or not to accept the application for insurance, to add a waiting period for pre-existing conditions (if state law allows it), and how much to charge for that insurance.

Medically necessary – services or supplies that are needed for the diagnosis or treatment of a medical condition, that meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the patient or doctor.

Medicare – a federally administered health insurance program that covers the costs of hospitalization, medical care and some related services for eligible persons. See also Original Medicare plan.

Medicare Advantage Disenrollment Period (MADP) – the time of year when Medicare beneficiaries can disenroll from an MA or MA-PD plan and return to Original Medicare. The Medicare Advantage Disenrollment Period is a 45-day period from January 1 through February 14. Members who disenroll during this period return to Original Medicare. They can also enroll in a stand-alone prescription drug plan at this time, regardless of whether the plan they are disenrolling from includes prescription drug coverage.

Medicare Advantage (MA) plan – a type of Medicare health plan offered by a private company that contracts with Medicare and receives a capitated payment to provide all of a beneficiary's Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage (MA) plans are HMOs, PPOs, private fee-for-service plans, Special Needs Plans (SNPs) or Medicare Medical Savings Account (MSA) plans. If a beneficiary is enrolled in an MA plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare plan. Most MA plans offer Medicare Part D prescription drug coverage.

Medicare Advantage-Prescription Drug (MA-PD) plan – a Medicare Advantage plan that includes Part D prescription drug benefits.

Medicare-approved amount – in the Original Medicare plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance or copay that the member pays. It may be less than the actual amount a doctor or supplier charges.

Medicare Cost plan – a type of Medicare health plan offered by a private company that contracts with Medicare and receives reimbursement for actual claims costs plus administrative fees. Cost plans coordinate with Original Medicare for Part A services, but function as the single, primary payer for most Part B services. They are often described as a "hybrid" between Medigap and Medicare Advantage plans and require the member to use in-network contracted providers to receive the highest level of benefits.

Medicare Medical Savings Account (MSA) plan – MSA plans combine a high-deductible Medicare Advantage plan (like an HMO or PPO) with a Medical Savings Account.

Medicare Prescription Drug Plan (Part D or PDP) – a stand-alone drug plan offered by private companies to people who get benefits through the Original Medicare plan, a Medicare private fee-for-service plan that doesn't offer prescription drug coverage, a Medicare Cost plan that doesn't offer prescription drug coverage, or a Medicare Medical Savings Account plan. Medicare Advantage plans may also include Part D coverage in an MA-PD plan.

Medicare health plan – any Medicare Advantage, Medicare Part D and/or Medicare Cost plan offered by an organization that holds a contract with CMS to offer such plan.

Medicare SELECT – a type of Medigap policy that requires members to use providers within a contracted network to be eligible for full benefits.

Medicare Supplement plan – see Medigap.

Medication Therapy Management (MTM) program – offered as part of prescription drug plan coverage to eligible Medicare beneficiaries who have multiple medical conditions, take several medications and have high prescription drug costs. MTM programs are designed to help beneficiaries avoid harmful drug interactions and to make sure the drugs they take are safe and effective. Nurses and pharmacists work with beneficiaries to review their medications and provide helpful information about their conditions.

Medigap – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 14 standardized plans labeled Plan A through Plan N. Medigap policies only work with Original Medicare.

Member ID – an ID number assigned to a member to identify the individual member within the group.

Multi-source – a drug which is available from multiple manufacturers. This usually refers to generics. Multi-source patented refers to drugs that are available from two or more manufacturers but that are not available as generics.

N

Non-formulary – a drug that has not been approved for inclusion in the drug formulary.

Non-Preferred – brand-name and generic drugs for which there are less expensive brand options or generic equivalents. The Non-Preferred drug tier includes non-preferred brand drugs and non-preferred generic drugs.

O

Open Enrollment Period (Medigap) – a six-month period when federal law allows a beneficiary to enroll in any Medigap policy sold in their state without being subject to health history underwriting. The Open Enrollment Period for Medigap plans begins with the effective date of Part B benefits. Some states have additional open enrollment periods under state law. If the state allows beneficiaries to enroll before age 65, then beneficiaries eligible for Part B prior to age 65 will receive a second Medigap Open Enrollment Period at age 65.

Original Medicare plan – the Original Medicare plan has two parts: Part A (hospital insurance) and Part B (medical insurance). It is a fee-for-service health plan. Medicare pays its share of the Medicare-approved amount for a service and members must pay the deductibles, copays and/or coinsurance as defined by the benefit.

Out-of-network – care received from providers who are not participating in the plan's contracted network. Members usually pay more for these services since they are not provided at the lower in-network rate.

Out-of-network pharmacy – pharmacies that are not in the plan's contracted network.

Out-of-pocket (OOP) costs – the amount a member is required to pay for health services and/or covered drugs in a calendar year. This does not include the amount that the plan has paid or the premium costs that members pay.

Out-of-pocket maximum – the total amount members pay for medical services each year (including deductibles, copays and coinsurance) before the plan pays 100 percent of remaining eligible medical expenses.

Over-the-counter (OTC) – a drug product that does not require a prescription to purchase. Most benefit plans do not cover these items, even though a prescription may have been written for them. Some benefit plans cover only a small subset of these drugs.

P

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – a premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. The Social Security Administration assesses the amount annually based on the enrollee's available tax information and notifies individuals who are affected. This amount is in addition to any late enrollment penalty that may apply.

PCP – see Primary care physician.

Penalty – an amount that may be added to a member's monthly premium for Medicare Part B or Medicare Part D if the member did not join when first eligible. This penalty is paid in addition to the premium as long as the member is enrolled. For Part B, the penalty is 10% for each year that the beneficiary could have enrolled but did not. For Part D, the penalty is 1% of the national average monthly premium in the enrollment year for each month enrollment is delayed. Some exceptions do apply.

Pharmacy network – a national network of contracted chain and local pharmacies that will recognize and accept a member's identification card for prescriptions.

Plan Sponsor – any health plan with a CMS contract.

Point-of-service – a health maintenance organization (HMO) option that lets members use doctors and hospitals outside the plan for an additional cost.

Pre-existing condition – a health condition a member had been diagnosed with before the date that a new insurance policy started.

Preferred Brand –The Preferred Brand drug tier includes preferred brand drugs and non-preferred generic drugs.

Preferred cost sharing – when a prescription drug plan has pharmacies that offer preferred cost sharing and pharmacies that offer standard cost sharing, drugs purchased at those with preferred cost sharing may have lower copays or coinsurance than drugs purchased at those with standard cost sharing.

Preferred Generic –the most cost-effective and commonly prescribed drugs used to treat a condition. This lowest drug tier includes preferred generic drugs and some preferred brand-name drugs.

Preferred provider organization (PPO) – a health plan with a network of physicians, specialists, hospitals and other providers where members receive their highest level of benefits when contracted providers (in-network) are used. Members may pay more for services received from out-of-network providers.

Premium – amount a member pays each month to receive coverage from a health or prescription drug plan.

Prescription Drug Plan (PDP) – a stand-alone Medicare Part D prescription drug plan that beneficiaries can enroll in if they have Original Medicare only, or a Medigap or Medicare Cost plan.

Preventive services – health care to keep members healthy or to prevent illness. For example, flu shots and cancer screening services.

Primary care physician (PCP) – a doctor who is trained to give basic care. A primary care physician is the doctor a member sees first for most health problems. He or she makes sure that a member gets necessary care to stay healthy. He or she may also talk with other health care providers or provide referrals for the member. In some Medicare Advantage plans, a member must see a primary care physician and receive a referral before seeing any other health care provider for benefits to apply.

Prior authorization – a program which requires that specific criteria be met before a member's service or drug may be covered.

Private fee-for-service (PFFS) plan – a type of Medicare Advantage plan (Part C) in which a member may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than Medicare, decides how much it will pay and what the member will pay for services. A member may pay more or less for Medicare-covered benefits, and may have extra benefits that are not usually offered by Original Medicare. Most PFFS plans do not have contracted provider networks.

Providers – doctors, other health care professionals, hospitals and other health care facilities that provide health care services.

Q

Quantity limits – a quantity maximum applied to a medication based on scientific and clinical reasoning. Quantity limits are applied to the number of days supply or number of units dispensed.

R

Referral – a written order from a primary care physician for a member to see a specialist or get certain services. In many HMOs, members need a referral before getting care from anyone other than their primary care doctor. If a referral is not obtained first, the plan may not pay for the service.

Retail pharmacy – a licensed, non-wholesale pharmacy open to the public.

S

Sales person – includes independent agents, brokers, employees of the Plan Sponsor and other marketing entities contractually obligated to the plan who market and sell the plan's products.

Scope of Appointment form – a form that must be signed by a beneficiary and returned to the sales person prior to any personal/individual sales/marketing appointment. The form documents which products will be discussed during the appointment. Only products documented on the scope of appointment form can be discussed unless the beneficiary requests additional product information. This requirement can also be met by a recorded phone conversation using a CMS approved script.

Single-source – a term used when a drug can only be purchased from one source, usually the original manufacturer.

Skilled nursing facility (SNF) care – this is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (such as help with activities of daily living, like bathing and dressing) do not qualify for Medicare coverage in a skilled nursing facility if that's the only care needed. However, if a member qualifies for coverage based on a need for skilled nursing care or rehabilitation, Medicare will cover all of the care needs in the facility, including help with activities of daily living.

Special enrollment period (SEP) – an enrollment opportunity for a beneficiary to enroll in, disenroll from or change coverage due to special circumstances. A special enrollment period may occur during the year if the member:

- Has eligibility changes, such as losing employer group health coverage including prescription drug coverage, or becoming eligible for Medicaid
- Moves into or out of a plan's service area
- Is in a Medicare-approved plan that was not renewed or ceases operation
- Wants to enroll in a 5-Star plan
- Other special circumstances

Special Needs Plan (SNP) – a special type of Medicare Advantage plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Specialty Tier – very high-cost brand-name drugs and some generic drugs, which may require special handling and/or close monitoring.

Standard cost sharing – when a prescription drug plan has pharmacies that offer preferred cost sharing and pharmacies that offer standard cost sharing, drugs purchased at those with standard cost sharing may have higher copays or coinsurance than drugs purchased at those with preferred cost sharing.

Star Rating – each year, Medicare rates how plans perform in different categories such as detecting and preventing illness, ratings from patients, patient safety and customer service. The rating system is designed to provide consumers with additional information to help them choose among the Medicare plans offered in their area. Both Medicare Advantage and prescription drug plans are rated. Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.

State Health Insurance Assistance Program (SHIP) – a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State insurance department – a state agency that regulates insurance and can provide information about Medigap policies and other private insurance.

Step therapy – a program which requires use of one or more specific drugs prior to the use of a more expensive drug or more potent dosages or higher quantities of other drugs.

T

Therapeutic alternative – a chemically different drug that would be expected to produce similar results to the drug in question.

Therapeutic equivalent – pharmaceutical equivalents that are expected to have the same clinical effect and safety profile as another medication when administered under the conditions specified in labeling.

Tier – see Drug tier.

Total drug costs – the total amount a member has paid plus what the plan has paid for the calendar year, not including premiums.

True Out-of-Pocket (TrOOP) costs – the amount the Medicare beneficiary pays in covered drug costs, such as deductibles, coinsurance and/or copays. If a beneficiary pays out of pocket

for a medication that is not considered a covered Part D drug, the cost is not applied toward calculation of TrOOP costs.

TTY – a teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing or have a severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

U

Utilization management (UM) – the use of scientifically based medical guidelines to promote the most beneficial and effective usage of medication. Utilization management programs include step therapy, quantity limits and prior authorization.

V

W

Waste – the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

X/Y/Z