2019 Annual Certification

Medicare Basics and Beneficiary Rights Course

Updated June 29, 2018

Welcome to SilverScript University

At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans.

CMS requires that marketing agents and brokers be tested annually on rules, regulations, and details about the products they sell.

To help you properly represent your agency and our products, we have developed a training & certification program.

- The program consists of several easy-to-follow online training courses.
- Each module presents information on a different subject, testing your knowledge along the way with questions on what you have learned.
- Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next course.

Once you pass all courses:

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

Welcome to SilverScript University

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

Course Objective

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

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

Medicare Parts and Covered Services

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

There are 4 different types of Medicare:

Part A, Part B, Part C and Part D

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

Descriptions of Medicare Options

Original Medicare – also called Fee-for-Service

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

Medicare Advantage – also called Medicare Part C or MA

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

Medicare Part D (MA-PDs and PDPs)

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

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

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

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

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

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

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

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

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

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

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

Medicare Part A Premiums

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

Medicare Part B Premiums, Deductible and Coinsurance

People pay a premium each month for Part B.

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

Most people will pay the standard premium amount.

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

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

People will pay a different amount if:

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

There is a Part B deductible and coinsurance.

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

Overview of Medicare Advantage Plans

Medicare Advantage (MA) or Medicare Part C plans

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

Medicare Advantage Plan Types

There are different types of Medicare Advantage plans.

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

There are other types of Medicare health plans.

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

Health Maintenance Organizations (HMOs)

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

Health Maintenance Organization (HMO) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

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

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

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

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

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

Preferred Provider Organization (PPO) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- No.

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

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

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

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

Private Fee-for-Service (PFFS) General Details

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

- Members can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat them. Not all providers will.
- If Medicare beneficiaries join a PFFS plan that has a network, the member can also see any of the network providers who've agreed to always treat plan members. Members can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but members may pay more. Check with the plan for more information.

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- No.

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

- No.

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

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

Special Needs Plans (SNP) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- Generally, yes.

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

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

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

- A plan must limit membership to these groups: 1) people who live in certain institutions (like nursing homes) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, ESRD, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Plans should coordinate the services and providers its members need to help members stay healthy and follow doctor's or other health care provider's orders.

Other Types of Medicare Health Plans - Medicare Cost Plans

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

Other Types of Medicare Health Plans - PACE

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

Other Types of Medicare Health Plans - Medicare Innovation Projects

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

General Provisions of Medicare Advantage Plans

What are Medicare Advantage plans?

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

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

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

General Provisions of Medicare Advantage Plans

Medicare Advantage Plans must follow Medicare's rules.

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

Different Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) plans

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

Preferred Provider Organization (PPO) plans

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

Private Fee-for-Service (PFFS) plans

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

Special Needs Plans (SNPs)

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

Different Types of Medicare Advantage Plans

HMO Point-of-Service (HMOPOS) plans

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

Medical Savings Account (MSA) plans

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

Medicare Advantage Considerations

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

Joining and Leaving a Medicare Advantage Plan

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

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

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

Prescription Drug Coverage with a Medicare Advantage Plan

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

Medicare Advantage Plan Costs

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

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

General Provisions of Medicare Supplement Insurance (Medigap)

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

General Provisions of Medicare Supplement Insurance (Medigap)

Important Facts

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

General Provisions of Medicare Supplement Insurance (Medigap)

When to Buy

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

Overview of Medicaid

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

Medicaid Qualifications

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

General Provisions of Prescription Drug Plans

Medicare offers prescription drug coverage to everyone with Medicare.

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

Joining and Leaving a Medicare Drug Plan

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

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

Medicare Drug Plan Costs

Actual drug plan costs vary depending on:

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

Monthly Premium

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

Yearly Deductible

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

Copayments or Coinsurance

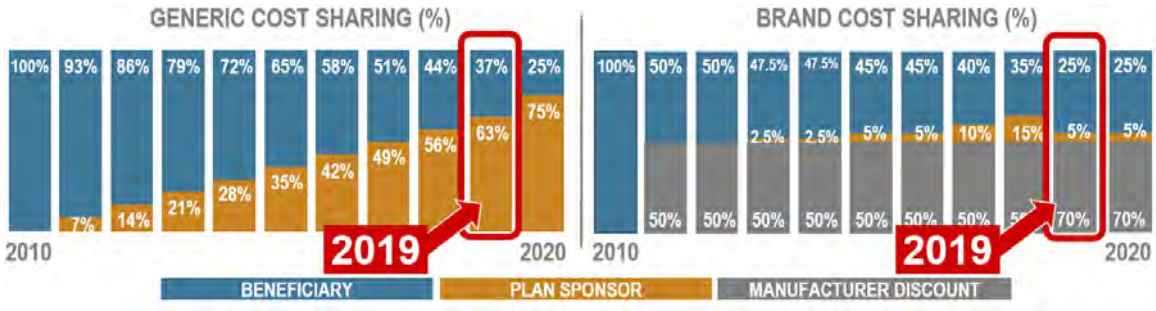
- These are the amounts members pay for their covered prescriptions after the deductible (if the plan has one). Members pay their share and the drug plan pays its share for covered drugs. These amounts may vary.

Medicare Drug Plan Costs - Coverage Gap

Coverage Gap

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

Coverage Gap Cost Sharing



On the path to a 25% cost share.

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

Medicare Drug Plan Costs - Catastrophic Coverage

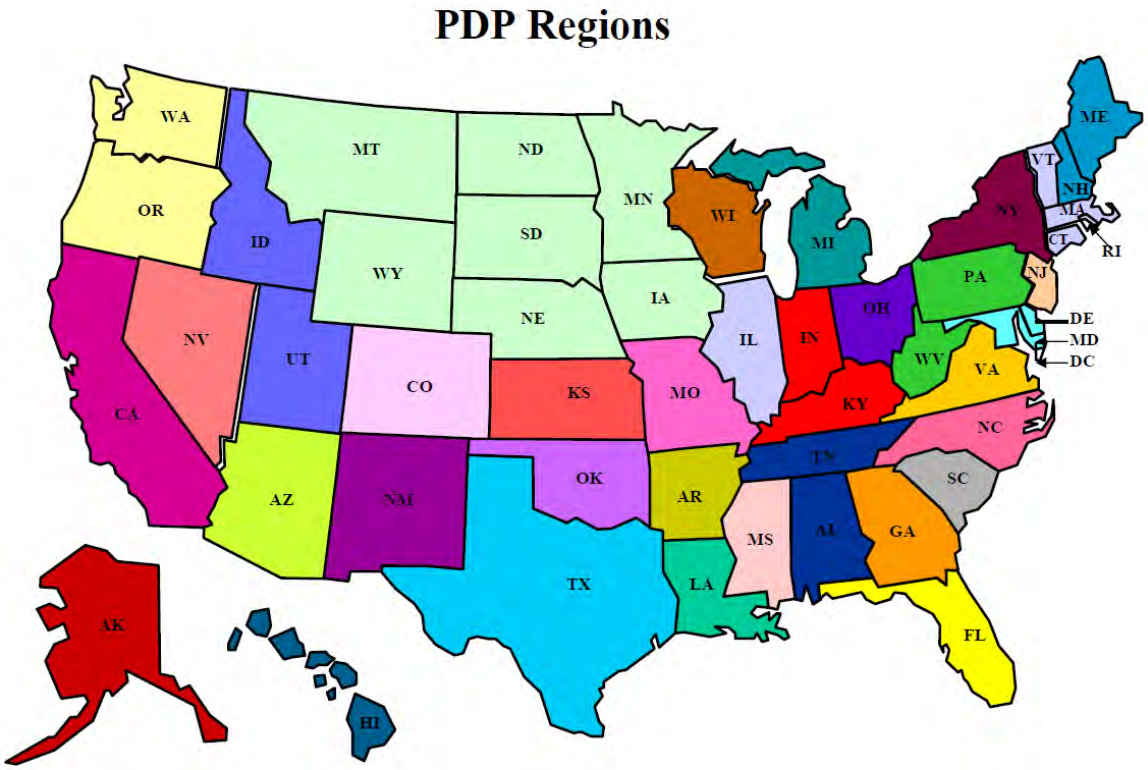
Catastrophic Coverage

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

Medicare Part D Service Areas

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

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



Note: Each territory is its own PDP region.

Medicare Part D Standard Benefit Parameters

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

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

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

Applies toward TrOOP

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

Does not apply toward TrOOP

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

Formulary and Formulary Requirements

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

Part D Excluded Drugs

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

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

Cost-Sharing Tiers

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

Important Drug Coverage Rules

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

Prior authorization

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

Quantity limits

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

Step therapy

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

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

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

Temporary Supply and Transition Fill Process

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

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

Beneficiary Rights

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

These rights include:

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

Coverage Determinations

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

Appeals and Grievances

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

Extra Help for People with Limited Income

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

Extra Help for People with Limited Income

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

Low Income Subsidy (LIS) Benefits

LIS Benefits fall into 2 categories:

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

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

Summary

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

This section was designed to provide you with an overview of Medicare Basics and Beneficiary Protections. Other courses address Enrollment, Marketing Guidance, and Product-Specific details.

WARNING!

You are about to begin the knowledge assessment.

DO NOT use your internet browser's back button or right click to back up to the previous screen.

ONLY use the navigation arrows at the right of each test question. The use of the browser's back/forward buttons may cause errors in calculating your test score and this may lead to your failing the test.

Remember, you only have 3 attempts to pass each course.

REMINDER:

You can download a PDF of this course from the SilverScript Agent Portal's Reference Materials page. Feel free to consult the PDF while you are taking the quiz.

2019 Annual Certification

Medicare Basics and Beneficiary Rights Course

Updated June 29, 2018

Welcome to SilverScript University

At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans.

Each year, CMS provides agent and broker requirements for training and testing. Part D sponsors are responsible for ensuring:

- All agents and brokers (including employed) that sell Medicare products are trained and tested annually on Medicare rules and regulations, and details specific to the plan products they are selling. This includes employees, subcontractors, downstream entities, and/or delegated entities.
- That training and testing procedures are put in place to ensure each individual is taking the test independently, maintaining the integrity of the training and testing program.
- That information on training and testing programs is provided to CMS upon request. CMS may request information that includes, but is not limited to, training tools, training exams, policies and procedures, and documentation demonstrating evidence of completion.

Welcome to SilverScript University

To help you properly represent our products, we have developed a training & certification program.

- The program consists of several easy-to-follow online training courses.
- Each course presents information on a different subject, testing your knowledge along the way with questions on what you have learned.
- Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next course.

Once you pass all courses:

- You will be permitted to view plan offerings and represent SilverScript prescription drug plans.

As you move forward, please take your time and pay close attention to the information presented in the training courses. If you have any questions, please contact your supervisor.

- We have placed PDFs of the training courses on the SilverScript Agent Portal under Reference Materials.
- Feel free to print the training materials and reference them as you take the certification test.
- You must pass each course within three attempts to represent SilverScript Medicare Part D plans.
- We want you to be well informed as you discuss our PDPs.

Course Objective

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

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

Medicare Parts and Covered Services

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

There are 4 different types of Medicare:

Part A, Part B, Part C and Part D

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

Descriptions of Medicare Options

Original Medicare – also called Fee-for-Service

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

Medicare Advantage – also called Medicare Part C or MA

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

Medicare Part D (MA-PDs and PDPs)

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

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

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

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

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

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

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

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

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

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

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

Medicare Part A Premiums

Most individuals are eligible for premium-free Part A if they are age 65 or older and they or a spouse worked and paid Medicare taxes for at least 10 years.

Individuals can get Part A at age 65 without having to pay premiums if the person:

- Is receiving retirement benefits from Social Security or the Railroad Retirement Board.
- Is eligible to receive Social Security or Railroad benefits but has not yet filed for them.
- Or a spouse had Medicare-covered government employment.

Individuals (or a spouse) who did not pay Medicare taxes while working, and who are age 65 or older and a citizen or permanent resident of the United States, may be able to buy Part A. In 2018, people who had to buy Part A paid premiums up to $422 each month. Visit Medicare.gov to find out the amount for 2019.

Individuals who are under age 65 can get Part A without having to pay premiums if the person:

- Has been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months (Note: If the person has Lou Gehrig's disease, then Medicare benefits begin the first month of disability benefits).
- Is a kidney dialysis or kidney transplant patient.

Medicare Part B Premiums, Deductible and Coinsurance

People pay a premium each month for Part B.

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

Most people will pay the standard premium amount.

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

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

People will pay a different amount if:

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

There is a Part B deductible and coinsurance.

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

Overview of Medicare Advantage Plans

Medicare Advantage (MA) or Medicare Part C plans

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

Medicare Advantage Plan Types

There are different types of Medicare Advantage plans.

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

There are other types of Medicare health plans.

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

Health Maintenance Organizations (HMOs)

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

Health Maintenance Organization (HMO) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

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

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

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

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

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

Preferred Provider Organization (PPO) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- No.

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

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

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

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

Private Fee-for-Service (PFFS) General Details

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

- Members can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat them. Not all providers will.
- If Medicare beneficiaries join a PFFS plan that has a network, the member can also see any of the network providers who've agreed to always treat plan members. Members can also choose an out-of-network doctor, hospital, or other provider, who accepts the plan's terms, but members may pay more. Check with the plan for more information.

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- No.

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

- No.

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

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

Special Needs Plans (SNP) General Details

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

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

Are prescription drugs covered?

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

Do members need to choose a primary care doctor?

- Generally, yes.

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

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

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

- A plan must limit membership to these groups: 1) people who live in certain institutions (like nursing homes) or who require nursing care at home, or 2) people who are eligible for both Medicare and Medicaid, or 3) people who have specific chronic or disabling conditions (like diabetes, ESRD, HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership.
- Plans should coordinate the services and providers its members need to help members stay healthy and follow doctor's or other health care provider's orders.

Other Types of Medicare Health Plans - Medicare Cost Plans

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

Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.

- **Medicare Cost Plans** - a type of Medicare health plan available in certain areas of the country.
    - Medicare beneficiaries can join even if they only have Part B.
    - If they have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. Members would pay the Part A and Part B coinsurance and deductibles.
    - Medicare beneficiaries can join anytime the Cost Plan is accepting new members.
    - Members can leave anytime and return to Original Medicare.
    - Members can either get their Medicare prescription drug coverage from the Cost Plan (if offered), or they can join a Medicare Prescription Drug Plan.

Other Types of Medicare Health Plans - PACE

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

Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.

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

Other Types of Medicare Health Plans - Medicare Innovation Projects

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

Some of these plans provide Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, while most others provide only Part B coverage. In addition, some also provide Part D prescription drug coverage. These plans have some of the same rules as Medicare Advantage Plans.

- Medicare Innovation Projects - Medicare develops innovative models, demonstrations, and pilot projects to test and measure the effect of potential changes in Medicare.
- These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only for a limited time for a specific group of people and/or are offered only in specific areas.
- Some examples include certain Accountable Care Organizations.

General Provisions of Medicare Advantage Plans

What are Medicare Advantage plans?

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

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

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

General Provisions of Medicare Advantage Plans

Medicare Advantage Plans must follow Medicare's rules.

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

Different Types of Medicare Advantage Plans

Health Maintenance Organization (HMO) plans

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

Preferred Provider Organization (PPO) plans

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

Private Fee-for-Service (PFFS) plans

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

Special Needs Plans (SNPs)

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

Different Types of Medicare Advantage Plans

HMO Point-of-Service (HMOPOS) plans

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

Medical Savings Account (MSA) plans

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

Medicare Advantage Considerations

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

Joining and Leaving a Medicare Advantage Plan

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

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

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

Prescription Drug Coverage with a Medicare Advantage Plan

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

Medicare Advantage Plan Costs

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

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

General Provisions of Medicare Supplement Insurance (Medigap)

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

General Provisions of Medicare Supplement Insurance (Medigap)

Important Facts

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

General Provisions of Medicare Supplement Insurance (Medigap)

When to Buy

The best time to buy a Medigap policy is during the person's Medigap Open Enrollment Period.

- This 6-month period begins on the first day of the month in which a person is 65 or older and enrolled in Part B. (Some states have additional Open Enrollment Periods.)

- After this enrollment period, people may not be able to buy a Medigap policy.
- If people are able to buy one, it may cost more.
- If people delay enrolling in Part B because they have group health coverage based on their (or their spouse's) current employment, their Medigap Open Enrollment Period won't start until they sign up for Part B.
- Federal law generally doesn't require insurance companies to sell Medigap policies to people under 65.

    - If people are under 65, they might not be able to buy the Medigap policy they want, or any Medigap policy, until they turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65.

Overview of Medicaid

Medicaid is a joint federal and state program that helps pay medical costs if you have limited income and resources and meet other requirements.

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

Medicaid Qualifications

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

General Provisions of Prescription Drug Plans

Medicare offers prescription drug coverage to everyone with Medicare.

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

Joining and Leaving a Medicare Drug Plan

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

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

Medicare Drug Plan Costs

Actual drug plan costs vary depending on:

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

Monthly Premium

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

Yearly Deductible

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

Copayments or Coinsurance

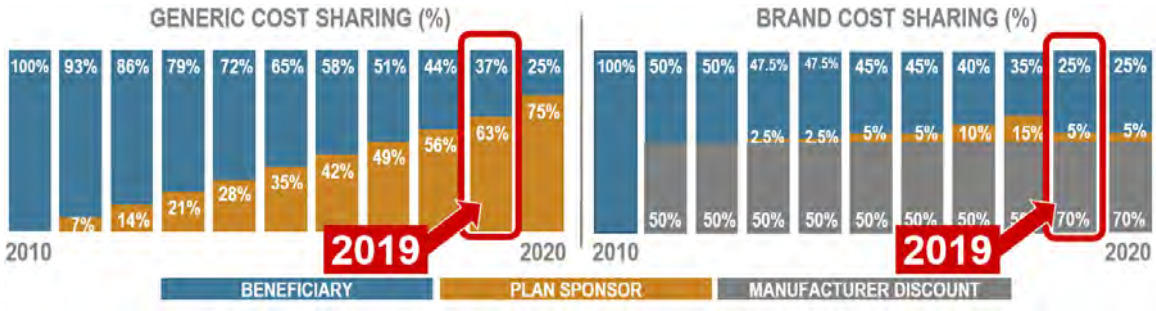
- These are the amounts members pay for their covered prescriptions after the deductible (if the plan has one). Members pay their share and the drug plan pays its share for covered drugs. These amounts may vary.

Medicare Drug Plan Costs - Coverage Gap

Coverage Gap

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

Coverage Gap Cost Sharing



On the path to a 25% cost share.

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

Medicare Drug Plan Costs - Catastrophic Coverage

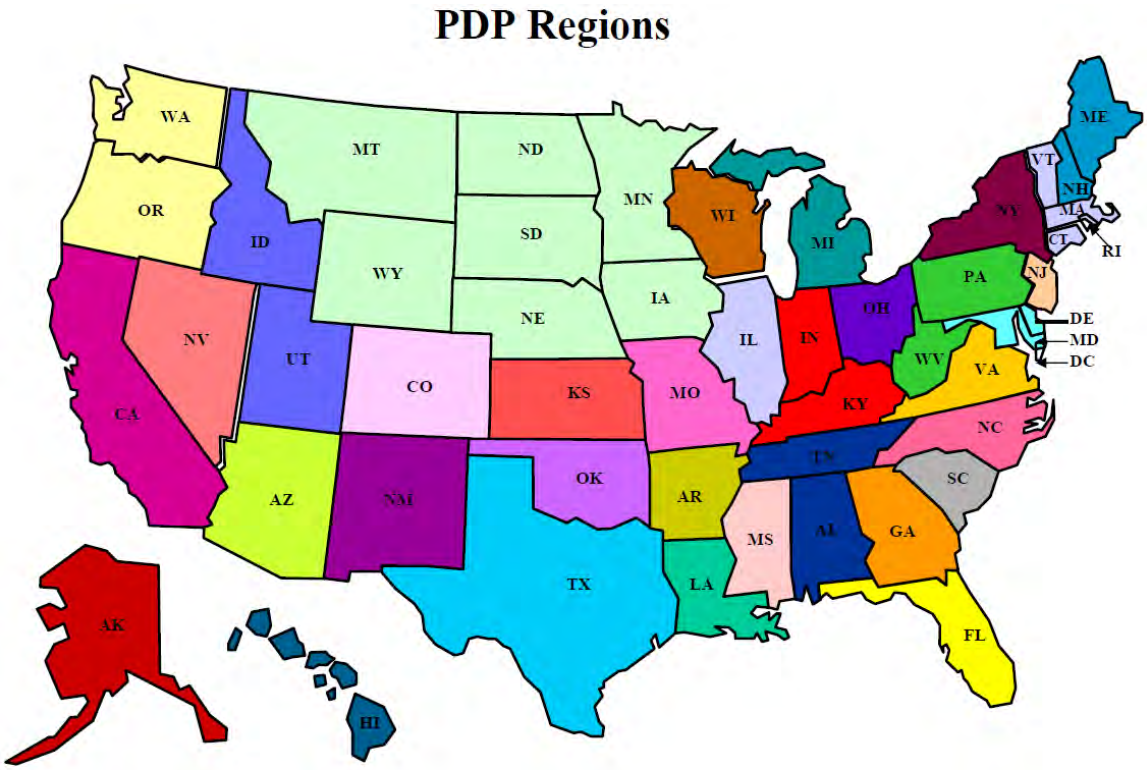
Catastrophic Coverage

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

Medicare Part D Service Areas

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

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



Note: Each territory is its own PDP region.

Medicare Part D Standard Benefit Parameters

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

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

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

Applies toward TrOOP

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

Does not apply toward TrOOP

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

Formulary and Formulary Requirements

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

Part D Excluded Drugs

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

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

Cost-Sharing Tiers

To have lower costs, many plans place drugs into different “tiers” on their drug lists (or formularies).

- The cost sharing for each tier is different.
- Each plan can divide its tiers in different ways.
- A drug in a lower tier will have lower cost sharing than a drug in a higher tier.
- A plan’s drug list might not include all drugs a member takes. However, in most cases, a similar drug that is safe and effective will be available.

Important Drug Coverage Rules

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

Prior authorization

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

Quantity limits

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

Step therapy

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

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

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

Temporary Supply and Transition Fill Process

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

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

Beneficiary Rights

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

These rights include:

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

Coverage Determinations

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

Appeals and Grievances

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

Extra Help for People with Limited Income

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

Extra Help for People with Limited Income

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

Low Income Subsidy (LIS) Benefits

LIS Benefits fall into 2 categories:

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

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

Summary

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

This section was designed to provide you with an overview of Medicare Basics and Beneficiary Protections. Other courses address Enrollment, Marketing Guidance, and Product-Specific details.

WARNING!

You are about to begin the knowledge assessment.

DO NOT use your internet browser's back button or right click to back up to the previous screen.

ONLY use the navigation arrows at the right of each test question. The use of the browser's back/forward buttons may cause errors in calculating your test score and this may lead to your failing the test.

Remember, you only have 3 attempts to pass each course.

REMINDER:

You can download a PDF of this course from the SilverScript Agent Portal's Reference Materials page. Feel free to consult the PDF while you are taking the quiz.

2019 Annual Certification

Agent/Broker Compliance Course

Updated June 29, 2018

Welcome to SilverScript University

At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans.

CMS requires that marketing agents and brokers be tested annually on rules, regulations, and details about the products they sell.

To help you properly represent your agency and our products, we have developed a training & certification program.

- The program consists of several easy-to-follow online training courses.
- Each module presents information on a different subject, testing your knowledge along the way with questions on what you have learned.
- Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next course.

Once you pass all courses:

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

Welcome to SilverScript University

- As you move forward, please take your time and pay close attention to the information presented in the training courses. If you have any questions, please contact your upline admin team. They are ready to support you.
- We have placed copies of the training courses on the SilverScript Agent Portal under the Training tab.
- Feel free to print the training materials and reference them as you take the certification test.
- You must pass each course within three attempts to sell SilverScript Medicare Part D plans.
- We want you to be well informed as you sell our PDPs.
- In addition to the training requirements, in order to sell Medicare products, an agent or broker must be appointed in accordance with the appropriate state's appointment law for each state the agent or broker is licensed.

Course Objective

SilverScript markets its Prescription Drug Plans (PDPs) through a select group of insurance carriers and national marketing organizations. As a marketing representative with one of SilverScript's marketing partners, your contract obligates you to:

- Abide by the rules, regulations and guidance issued by CMS.
- Abide by HIPAA and state privacy laws.
- Abide by the policies, procedures and guidelines issued by SilverScript.

At the completion of this training course, you should be familiar with the following:

- CMS Medicare Marketing Guidelines
- HIPAA guidelines
- SilverScript policies and procedures for agents/brokers
- Your reporting obligations

SilverScript & Medicare Part D

SilverScript contracts with CMS as plan sponsors to administer the Medicare Part D prescription drug benefit.

One aspect of our oversight program is to provide marketing representatives with proper training on how to comply with the Medicare Part D rules and regulations.

It is important that you understand and comply with guidelines as defined by CMS, HIPAA regulations, and SilverScript because:

- You are in a position to affect the decision of potential beneficiaries regarding their plan choice.
- You are held accountable for your activities in the Medicate Part D marketplace.
- SilverScript is ultimately responsible for your activities when representing our PDPs and group products.

You are held accountable to comply with all federal and state privacy and security laws.

Protected Health Information (PHI)

The HIPAA Privacy Rule standards address the use and disclosure of an individual's health information, called Protected Health Information (PHI). PHI is any information that can be used to identify an individual and that is obtained by or on behalf of a health plan or health care provider.

- The Privacy Rule protects all PHI held or transmitted in any form or media, whether electronic, paper or oral, by a covered entity (such as SSIC) or its business associate (such as you).
- PHI includes information that relates to:
    - The individual's past, present or future physical or mental health or condition.
    - The provision of health care to the individual.
    - The past, present, or future payment for the provision of health care to the individual.
    - Information that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual.
- Examples of PHI include demographic information with any health diagnoses, medications, Medicare or SSN numbers, names of doctors, dates of treatment, etc.

Health Insurance Portability Accountability Act (HIPAA)

HIPAA protects the privacy and security of personal health information and provides assurance to individuals that their personal health information will not be misused.

- HIPAA establishes standards for certain electronic transactions and minimum privacy and security requirements.
- Your obligations under HIPAA were defined in the Business Associates Agreement you signed at the time of contracting. In particular:
    - Use and disclose PHI only for purposes for which it was provided (i.e. marketing and enrollment in a SilverScript plan).
    - Use and disclose only the minimum necessary PHI for a particular task.
    - Always keep PHI secure. (e.g. Don't leave documents containing PHI on your desk when you go out, stand by the fax machine when expecting a fax with PHI if the fax machine is not in a secure area, and don't send PHI unencrypted over public networks.)
    - Always encrypt PHI when sending over public networks.

Anti-Kickback Statute

One important law that governs the behavior of marketing agents is the Anti-Kickback Statute.

- This law prohibits anyone from offering inducements to purchase or use health products or services if these products or services are reimbursable in whole or in part by the federal government.
- Importantly, a violation of this statue can result in exclusion from participation in the Medicare Part D program and other federal healthcare programs. In addition, this statute carries both civil and criminal penalties for violation.

CMS Regulations

One of the primary regulations that govern your activities as a Medicare Part D marketing agent is the Part D rule found in the Code of Federal Regulations (CFR) Title 42. Parts 422, 423 and 417.

- Each year CMS issues updates to the Prescription Drug Benefit Manual. The manual contains detailed operational guidance based on the governing law defined in CFR. The focus of this training course is on Medicare Marketing Guidelines (MMG) of the manual, "The Medicare Marketing Guidelines for Medicare Advantage plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and 1876 Cost Plans."
- The following slides describe the do's and don'ts for your marketing activities as described in MMG of the Prescription Drug Benefit Manual.

Marketing and Sales Oversight

Marketing includes any activity of an employee of a plan sponsor, an independent agent, or an independent broker or any other person that acts on a plan sponsor's behalf to affect a beneficiary's choice among Medicare plans.

- Marketing by a person who is directly employed by an organization with which a plan sponsor contracts to perform marketing or a downstream marketing contractor is considered marketing by the plan sponsor.
- You may not charge a beneficiary a marketing fee or any other fee. The only amount that the beneficiary is required to pay is the plan's approved premium (which is to be paid directly to the plan), and the plan may use a portion of that to compensate a marketing representative.

Licensure and State Appointment Laws

Agents must be actively licensed in the beneficiary's state of residence at the time of the marketing activity and enrollment.

- The use of state-licensed marketing representatives helps ensure that:
    - A minimum standard of integrity and professionalism is displayed when marketing to Medicare-eligible beneficiaries; and
    - Medicare beneficiaries are not the victims of substandard or inappropriate marketing activities.
- In order to market SilverScript plan offerings, you must:
    - Be licensed in the state in which you conduct marketing activities;
    - Meet the necessary state educational requirements;
    - Be appointed by the plan in accordance with state appointment regulations; and
    - Obtain your training certification by passing the training modules at the required level (as described in the beginning of this module).
- In order to sell Medicare products, plan sponsors must comply with applicable State licensure and/or appointment laws.

Activities That Do Not Require the Use of State-Licensed Marketing Representatives

The following activities conducted by a plan customer service representative do not require the use of state-licensed marketing representatives, unless otherwise stated by state law. These include:

- Providing factual information;
- Fulfilling a request for materials;
- Taking demographic information in order to complete an enrollment application at the initiative of the prospective enrollee;
- “For-cause” review of materials and activities when complaints are made by any source, and CMS determines it is appropriate to investigate; and
- "Secret shopper” activities where CMS requests Plan/Part D Sponsor materials such as enrollment packets.

- However, if Plans/Part D Sponsors use licensed agents/brokers (employed or contracted) as customer service representatives, they cannot act as both a customer service representative and a sales/marketing agent/broker.

Plan Reporting of Terminated Agents

- Plan sponsors must immediately report the termination of any agents/brokers to the State (adhering to state requirements for reporting terminations to the state) and the reasons for the termination, if State law requires the reasons to be reported.
- Plan sponsors must report for-cause terminations to CMS Account Managers. Plan sponsors must also report to CMS Account Managers any sales of Medicare products which were made by agents without a valid license.

If a Plan sponsor discovers an enrollment application was submitted by an unlicensed agent or broker, the plan sponsor must immediately terminate the agent or broker and report this action to the State where the application was submitted.

- Additionally, plan sponsors must notify any beneficiaries who were enrolled by unqualified agents/brokers (e.g., unlicensed, not appointed, or has not completed the annual training/testing) and advise those beneficiaries of the agents'/brokers' status.
- Beneficiaries may request to make a plan change.

Background Check

SilverScript is required to screen all marketing representatives against the Department of Health and Human Services (DHHS) and Office of the Inspector General (OIG) Lists of Excluded Individuals & Entities. This is done to ensure that the marketing representatives are not excluded from participation in any federal health care programs.

Marketing representatives found to be on these lists are immediately barred from marketing SilverScript PDPs and sanctions will be imposed for failure to disclose this information. However, if after being barred, a marketing representative is reinstated, a monitoring plan will be established to ensure that future business submitted by the marketing representative will be scrutinized in order to mitigate the risk of future non-compliance.

Agent/Broker Training and Testing

- Plan sponsors must ensure that all agents/brokers (employed/captive or independent) selling Medicare products are trained and tested annually on Medicare rules, regulations, and on details specific to the plan products that they sell.

  This means that training and testing must take place prior to the broker/agent selling the product.

- CMS provides updated guidance annually for agents/brokers training/testing. Plan sponsors must ensure that their agents/brokers training/testing programs are designed and implemented in a way that maintains the integrity of the training and testing, and must have the ability to provide this information to CMS upon request.
- In order to sell SilverScript's Medicare products, a broker or agent must receive a passing score of at least 90% on each certification test.

Agent/Broker Use of Marketing Materials

- Plan sponsors are responsible for all marketing materials used by their subcontractors to market their plans. All marketing materials used by plan sponsors or their subcontractors must be submitted to CMS by the plan sponsor that contracts with CMS (e.g., SilverScript) for review and approval prior to use. Marketing materials cannot be submitted directly by a third party to CMS. It is the responsibility of plan sponsors to ensure that all applicable materials created by a third party meet the requirements outlined in CMS' current marketing regulations guidance.

Agents and brokers must submit marketing materials to SilverScript for review and approval prior to distributing any materials to prospects, clients or members.

- All marketing material must be approved by SilverScript and by CMS.

Marketing

The following materials, while not an exhaustive list, may fall under CMS' purview per the definition of marketing materials:

- General audience materials such as general circulation brochures, direct mail, newspapers, magazines, television, radio, billboards, yellow pages, or the internet
- Marketing representative materials such as scripts or outlines for telemarketing or other presentations
- Presentation materials such as slides and charts
- Promotional materials such as brochures or leaflets, including materials circulated by physicians, other providers, or third party entities
- Membership communications and communication materials including membership rules, subscriber agreements, enrollee handbooks and wallet card instructions to enrollees (e.g., Annual Notice of Change (ANOC), Evidence of Coverage (EOC), Provider/Pharmacy Directory)
- Communications to enrollees about contractual changes, and changes in providers, premiums, benefits, plan procedures
- Communications related to membership activities (e.g., materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or non-claim specific notification information)
- The activities of a plan sponsor's employees, independent agents or brokers, subcontracted Third Party Organizations (TMO) (downstream contractors), or other similar type organizations that contribute to the steering of a potential enrollee toward a specific plan or limited number of plans, or may receive compensation directly or indirectly from a plan sponsor for marketing activities

Required Materials in Pre-Enrollment Package

When beneficiaries are provided with plan-specific marketing information that includes an enrollment/instruction form, they must also receive the following materials:

- Plan ratings information which must be a standalone document
    - Updated plan rating documents are available shortly after CMS releases the plan year ratings.
        - Agents are expected to replace the out-dated document with the updated form that is available for download via the SilverScript Agent Portal.
        - SilverScript will include the updated document in all pre-enrollment kits once the forms are approved and ready for distribution.
- Summary of Benefits (SB)
- The pre-enrollment kits are available for order and for download via the SilverScript Agent Portal.

Required Materials for New Enrollees

The following documents must be provided to all new enrollees no later than 10 calendar days from the receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever is earlier. In addition, these materials must be made available upon beneficiary request.

- Comprehensive Formulary or Abridged Formulary
- Pharmacy Directory
- Membership ID Card
- New enrollees with an effective date of January 1 or later must receive an EOC for the contract year of coverage.
- A cover letter that includes the plan's toll-free customer service telephone number, a TTY telephone number, customer service hours of operation, and a physical or post office address is optional since the contact information is included in the SB.
- SilverScript mails the Welcome Kits directly to new enrollees.

Required Materials for New and Renewing Members

Plan sponsors must ensure that their current/renewing members receive the Annual Notice of Change/Evidence of Coverage (ANOC/EOC) accompanied by the Low Income Subsidy (LIS) Rider no later than September 30th of each year.

New Enrollees with an effective date of November 1st or December 1st should receive both an EOC for the current contract year and an ANOC/EOC for the upcoming contract year.

- Renewing members are required to receive the following materials:
    - Combined ANOC/EOC
    - Low Income Subsidy (LIS) Rider, if applicable
    - Comprehensive Formulary or Abridged Formulary including information on how the beneficiary can obtain a complete formulary
    - A hard copy pharmacy directory, or separate notice to alert enrollees where they can find the pharmacy directory online and how they can request a hard copy
    - Membership ID Card (required only if a change is required by plan sponsor post-enrollment)
- We automatically mail these items to members.
- Part D sponsors must ensure that enrollees who utilize their prescription drug benefits in a given month receive their Explanation of Benefits (EOB) by the end of the month following the month in which they utilized their prescription drug benefits.

Star Ratings Information

- The Medicare program rates how well plan sponsors perform in different categories.
- Plan performance summary star ratings are assessed each year and may change from one year to the next.
- Star Ratings are generally issued in October of each year. Plan sponsors will be required to use updated Star Ratings information within 21 calendar days of the release of the updated information.
- Plan sponsors must provide Star Ratings information to beneficiaries through the standardized Star Ratings information document.
    - The Star Ratings information document must be distributed when the SB and/or the enrollment form is provided to beneficiaries.
- The Star Ratings information document must also be prominently posted on plan websites.
- Plan Sponsors are not permitted to display or release their Star Ratings information until CMS releases the Star Ratings on Medicare Plan Finder (MPF).

General Guidance about Promotional Activities

Promotional activities must comply with all relevant Federal and State laws.

- Plan sponsors may be subject to compliance and/or enforcement actions if they offer or give something of value to a Medicare beneficiary that the plan sponsor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare.
- Marketing representatives must clearly identify the types of products that will be discussed before marketing to a potential enrollee. This includes all sales presentations, events, appointments, and outbound calls that are designed to promote or encourage a beneficiary to enroll in a plan. Additionally, plan sponsors are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.
- Furthermore, plan sponsors are prohibited from offering or giving remuneration to induce the referral of a Medicare beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare program.

Marketing in a Health Care Setting

Marketing representatives may not conduct sales activities in healthcare settings except in common areas.

- Common areas where marketing activities are allowed include areas such as common entryways, vestibules, hospital or nursing home cafeterias, community, recreational, or conference rooms.
- If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services from or interact with pharmacy providers and obtain medications.

- Marketing representatives are prohibited from:
  - Conducting sales presentations, distributing and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily receive health care services or are waiting to receive health care services.
    - These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).
    - The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

Marketing in a Health Care Setting

- Agents are only permitted to schedule appointments with beneficiaries residing in long-term care facilities (including nursing homes, assisted living facilities, board and care homes, etc.) upon request by the beneficiary.
- Plan sponsors may use providers and/or facilities to distribute and/or make available plan marketing materials as long as the provider and/or the facility distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, a plan sponsor must only ensure that a provider/facility agrees to make available and/or distribute plan marketing materials and accept future requests from other plan sponsors with which the provider/facility participates. Plan sponsors may also provide materials for a provider's/facility's common area, such as the waiting room. Additionally, plan sponsors may provide long-term care facilities with materials for admission packets announcing all plan contractual relationships.
- Institutional Special Needs Plans (I-SNPs) are permitted to provide long term care facility staff with an I-SNP explanatory brochure to distribute to residents who meet the I-SNP criteria for enrollment. The brochure may explain the qualification criteria and the benefits of being enrolled in an ISNP. The brochure may have a reply card or telephone number for the resident, or responsible party, to call to request a meeting or additional information.

General Guidance about Promotional Items

Generally, promotional activities are designed to attract the attention of prospective enrollees and/or encourage retention of current enrollees. In addition to the guidance on nominal gifts, any promotional activities or items offered by plan sponsors must:

- Have only nominal value (be worth no more than $15) based on the fair market value of the item or less, with a maximum aggregate of $75 per person, per year.
- Be offered to all potential enrollees regardless of whether they enroll, and without discrimination.
- Not be items that are considered a drug/health benefit including optional mandatory supplemental benefits (e.g., a free checkup); and
- Not be tied directly or indirectly to the provision of any other covered item or service.

Note: plan sponsors should track and document items given to current enrollees. Plan sponsors are not required to track pre-enrollment promotional items on a per person basis; however, they may not willfully structure pre-enrollment activities with the intent to give people more than $75 per year.

Nominal Gifts

Plan sponsors may offer gifts to potential enrollees, as long as those gifts are of nominal value, provided regardless of enrollment, and without discrimination.

- The following rules must be followed when providing nominal gifts:
    - If a nominal gift is one large gift (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per-person value based on attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). For planning purposes, anticipated attendance may be used, but must be based on actual venue size, response rate, or advertisement circulation.
    - Nominal gifts may not be in the form of cash or other monetary rebates, even if their worth is $15 or less. Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.

Exclusion of Meals as a Nominal Gift

- Plan sponsors may not provide or subsidize meals at sales/marketing events.
- Plan sponsors may provide refreshments and light snacks.
- Plan sponsors should use their best judgment on the appropriateness of food products provided, and should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal.
- Meals may be provided at educational events, provided the event meets CMS’ strict definition of an educational event, and complies with the nominal gift requirement in regulations.

Unsolicited Electronic Communication Policy

- A plan sponsor may initiate separate electronic contact.
- Plan sponsors must provide an opt-out process for enrollees to no longer receive email or other electronic communications.
- Plan sponsors are prohibited from renting or purchasing email lists to distribute information about MA, PDP, or section 1876 cost plans, and may not send electronic communications to individuals at email addresses or on social media obtained through friends or referrals.

Marketing through Unsolicited Contacts

In general, plan sponsors may not market through unsolicited contacts, including but not limited to:

- Door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence or car.
- Approaching beneficiaries in common areas, (e.g., parking lots, hallways, lobbies, sidewalks, etc.).

  NOTE: Agents/brokers who have a pre-scheduled appointment that becomes a “no-show” may leave information at the no-show beneficiary’s/individual's residence.

- The prohibition on marketing through unsolicited contacts does not extend to conventional mail and other print media (e.g., advertisements, direct mail).
- In addition, permission given to be called or otherwise contacted must be event-specific, and may not be treated as open-ended permission for future contacts.

Rules for Telephonic Contact

Agents may contact their own clients and plan sponsors may contact current enrollees at any time to discuss plan business. Prohibited telephonic activities include, but are not limited to, the following:

- Bait-and-switch strategies - making unsolicited calls about other business as a means of generating leads for Medicare plans
- Calls based on referrals - if an individual would like to refer a friend or relative to an agent or plan sponsor, the agent or plan sponsor may provide contact information such as a business card that the individual may give to a friend or relative. Otherwise, a referred individual needs to contact the plan or agent/broker directly.
- Calls to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling (except as permitted on the next page), to market plans or products. Enrollees 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.
- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (the plan sponsor must have documentation of permission to be contacted).
- Calls to beneficiaries to confirm receipt of mailed information, except as permitted on the next page.

Rules for Telephonic Contact

Plan sponsors may conduct the following activities:

- Call beneficiaries who submit enrollment applications to conduct quality control and/or agent/broker oversight activities.
- Call their current MA and non-MA enrollees 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.
- Call their current MA enrollees to promote other Medicare plan types or to discuss plan benefits (e.g., sponsors may contact their PDP members to promote their MA-PD offerings; Plans/Part D Sponsors that are also Medigap issuers may market their MA, PDP, or cost plan products to their Medigap enrollees).
- Call their current enrollees, 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.

Rules for Telephonic Contact

Plan sponsors may conduct the following activities:

- Call their enrollees to conduct normal business related to enrollment in the plan, including calls to enrollees who have been involuntarily disenrolled to resolve eligibility issues.
- Call former enrollees after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Disenrollment surveys may be conducted telephonically or mailed. Surveys conducted in either manner may not include sales or marketing information.
- Under limited circumstances and subject to advance approval from the appropriate CMS Account Manager, call LIS-eligible enrollees 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 (BRC), sending an email to the Plan Sponsor requesting a return call, or asking a customer service representative (CSR) 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 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.

Enrollment Verification Requirements

- Plan sponsors are required to maintain a system to ensure beneficiaries are enrolled into the plan they requested and understand the rules applicable to that plan. This system must be maintained for all agent/broker assisted enrollments, including enrollment requests in which an independent or employed agent/broker provided plan-specific information to the individual, thus potentially influencing the individual's plan choice and/or assisting in a subsequent enrollment request.
- Plan sponsors have the option to complete the enrollment verification process by telephone, email (if beneficiary opted-in for email) or direct mail. The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request.
- Plan sponsors may integrate the enrollment verification process into an existing practice, such as welcome calls, without making a separate call for enrollment verification. If the plan sponsor chooses to utilize a telephonic contact but is unable to speak with the individual or his or her appointed/authorized representative directly, the plan sponsor must either continue call attempts or follow up with a written communication. The Plan Sponsor must document the timing and method of contact.

Enrollment Verification Requirements

Enrollment verification is expected to be made to the applicant after the sale has occurred and not at the point of sale. The plan sponsor is expected to ensure that enrollment verifications are not conducted by sales agents. Also, if calling or emailing applicants, plan sponsors are expected to ensure that sales agents are not physically present with the applicant at the time of the verification. The following agent/broker-assisted enrollments are excluded from the OEV requirement:

- Enrollments into employer or union sponsored plans
- 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)

Prospective Enrollee Educational Events

- An educational event is an event designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and does not include marketing (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans). Educational events may be hosted by the plan sponsor or an outside entity and are held in a public venue. These events cannot be held at in-home or one-on-one settings.
- Educational events for prospective enrollees may not include any sales activities including the distribution of marketing materials or the distribution/collection of plan applications. This includes the distribution of any material with plan-specific information (including plan-specific premiums, co-payments, or contact information). Educational events must be explicitly advertised as "educational," otherwise they will be considered by CMS as sales/marketing events.
- The intent of this guidance is not to preclude plan sponsors from informing beneficiaries about their products; rather, it is to ensure that events that are advertised as "educational" are only educational and comply with CMS' requirements. More specifically, plan sponsors may provide education at a sales or marketing event, but may not market or sell at an educational event.

Prospective Enrollee Educational Events

The following are examples of acceptable materials and activities by Plans/Part D Sponsors or their representatives at an educational event:

- A banner with the plan name and/or logo displayed
- 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.
- Responding to questions asked at an educational event

Prospective Enrollee Educational Events

At educational events, Plans/Part D Sponsors or their representatives may not:

- Discuss plan-specific premiums and/or benefits.
- Distribute plan-specific materials.
- Distribute or display business reply cards, scope of appointment forms, enrollment forms, or sign-up sheets.
- Set up individual sales appointments or get permission for an outbound call to the beneficiary.
- Attach business cards or plan/agent contact information to educational materials, unless requested by the beneficiary.
- Advertise an educational event and then have a marketing/sales event immediately following in the same general location (e.g., same hotel).

- These activities constitute prohibited sales activities at educational events.

Marketing/Sales Events and Appointments

Marketing/sales events are events designed to steer, or attempt to steer, potential enrollees toward a plan or limited set of plans. At marketing/sales events, plan representatives may discuss plan specific information and collect applications.

Plan sponsors must submit all sales scripts and presentations for approval to CMS prior to their use during the marketing/sales event.

Marketing/Sales Events and Appointments

At a marketing/sales event, Plans/Part D Sponsors may not:

- Conduct health screening or other like activities that could give the impression of “cherry picking.”
- Require beneficiaries to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through mail. Plan sponsors should clearly indicate on any sign-in sheets that completion of any contact information is optional.
- Use personal contact information obtained to notify individuals of raffle or drawing winnings for any other purpose.

Notifying CMS of Scheduled Marketing Events

Agents must notify SilverScript of all marketing/sales events prior to advertising the event or 7 calendar days prior to the event's scheduled date, whichever is earlier. For detailed instructions, including the earliest upload date, please refer to the Agent Portal Reference Materials tab.

- **We ask that agents submit the required information (i.e. time, date and place) about the event to SilverScript no later than 10 days preceding the event or before it is advertised, whichever is earlier.**
- **Email event information to ProducerSalesResource@cvscaremark.com.**
- In some situations, you will be able to schedule an event with less than 10 days advanced notice. Contact SilverScript as soon as you confirm an event.

- Changes to marketing/sales events, (e.g., cancellations and room changes), must be communicated to SilverScript at least 48 hours prior to the scheduled event.

Personal/Individual Marketing Appointments

All plan sponsor one-on-one appointments with beneficiaries, regardless of the venue (e.g., in home, conference call, library), are considered sales/marketing events and must follow the scope of appointment (SOA) guidance.

- The plan sponsor's representative may not do the following:
  - Discuss plan options that were NOT agreed to by the beneficiary.
  - Market non-health care related products (such as annuities or life insurance).
  - Ask a beneficiary for referrals.
  - Solicit/accept an enrollment request (application) for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.

Scope of Appointments

- When conducting marketing activities, a plan sponsor's agent/broker may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed to before the meeting. The Plan Sponsor must document the scope of the appointment prior to the appointment.
- Distinct lines of plan business include MA, PDP and Cost Plan products. If the agent/broker would like to discuss additional products during the appointment in which the beneficiary indicated interest, but did not agree to discuss in advance, the agent/broker must document a second scope of appointment (SOA) for the additional product type to continue the marketing appointment.

Scope of Appointments

To further clarify the requirements around documentation:

- SilverScript requires that the Scope of Appointment documentation be in writing. (The exception to this SilverScript policy is call center-based organizations. These entities are required to capture recorded oral agreements).
- Other plan sponsors may allow a variety of technological means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes, and e-mail, etc.; however, SilverScript does not allow these other methods.
- A beneficiary may set a scope of appointment at a marketing/sales event for a future appointment.

Scope of Appointments

The written Scope of Appointment (SOA) must include the following:

- 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 Medicare enrollment status will not be impacted.
    - The beneficiary is not automatically enrolled in the plan(s) discussed.

Beneficiary Walk-ins

Beneficiary Walk-ins to a Plan at Agent/Broker Office or Similar Beneficiary-Initiated Face-to-Face Sales

- In instances where a beneficiary visits an agent/broker office on his/her own accord, the plan sponsor or agent/broker must document the scope of appointment prior to discussing MA, PDP, or cost plans.

General Rules Regarding Compensation

All compensation requirements contained in this section apply to independent agents/brokers. Employed and captive agents/brokers who only sell for one Plan/Part D Sponsor are exempt from compensation requirements, except where noted (e.g., referral/finder fees). However, all other marketing and sales requirements must be met.

- Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fee.
- Compensation DOES NOT include:
    - The payment of fees to comply with state appointment laws;
    - Training;
    - Certification;
    - Testing costs;
    - Reimbursement for mileage to, and from, appointments with beneficiaries; or
    - Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

General Rules Regarding Compensation

Initial compensation may be paid at or below the fair market value (FMV) cut-off amounts published by CMS annually.

Renewal compensation may be paid for each enrollment in year 2 and beyond. Renewal compensation may be paid up to fifty (50) percent of the current FMV, published by CMS annually.

Referral/Finder's fees paid to agents and brokers, including independent, employed, and captive agents and brokers, may not exceed $100 ($25 for PDPs).

- This amount is not reasonably expected to provide enough financial incentive for an agent or broker to recommend or enroll a beneficiary into a plan that is not the most appropriate for the beneficiary's needs.
- Additionally, referral/finder's fees paid to all agents and brokers must be part of total compensation and must not exceed FMV for that contract year.

Enrollment Types for Compensation Purposes

A “like plan type” enrollment includes:

- A PDP to another PDP.
- An MA, MA-PD, or MMP to another MA, MA-PD, or MMP.
- A section 1876 cost plan to another section 1876 cost plan.

An “unlike plan type” enrollment includes:

- An MA or MA-PD plan to a PDP or section 1876 cost plan.
- A PDP to a section 1876 cost plan or an MA (or MA-PD) plan.
- A section 1876 cost plan to an MA (or MA-PD) plan or PDP.

Note: For dual enrollments (e.g., enrollment in an MA-only plan and a stand-alone PDP), the compensation rules apply independently to each plan. However, when dual enrollments are replaced by an enrollment in a single plan, compensation is paid based on the MA movement (e.g., movement from an MA-only plan and PDP to an MA-PD plan would be compensated at the renewal compensation amount for the MA to MA-PD “like plan type” move).

General Rules Regarding Compensation

- Plans/Part D Sponsors may not pay compensation to agents/brokers who have not been trained and tested, do not meet state licensure/appointment requirements or those who have been terminated for cause.
- When a Plan/Part D Sponsor and/or a contracted independent agent/broker terminates an agent/broker contract, any future payment of existing business will be governed by the terms of the contract, subject to the limits in the regulation.
- Note: Non-agents/brokers receiving referral fees are not subject to the general compensation rules (e.g., training/testing/licensure).

Compensation Payment Requirements

- Each year, Plans/Part D Sponsors may decide whether they are using employed, captive, and/or independent agents, as well as the amount within CMS' FMV limits they will compensate independent agents/brokers.
- Each year, CMS issues an HPMS memo that notifies Plans/Part D Sponsors of the FMV, and requires them to inform CMS yearly by the end of July whether they will use agents/brokers, including the types of agents/brokers, as well as the compensation payment ranges. Once the July deadline has passed, Plans/Part D Sponsors may not change what they submitted and attested to.
- In addition, Plans/Part D Sponsors must have in place their full agent/broker compensation structure for new and renewal enrollments by October 1 each year.
    - This structure supports the compensation payment ranges submitted earlier in the year and must be made available to CMS upon request.
    - The compensation structure includes how the Plan/Part D Sponsor plans to disseminate compensation to the agent/broker.
- **The agent/broker compensation year is January 1 to December 31.**
    - Compensation payments must be calculated on a January to December enrollment year.
    - They may not be made on a rolling basis or on an enrollment year based on the initial enrollment month.
    - For example, if a beneficiary's enrollment is effective September 1, then the initial enrollment year for that beneficiary ends on December 31 and the beneficiary's "renewal" year would begin in January of the following year.
    - Plans/Part D Sponsors should consult the MARx agent/broker compensation report to determine whether an initial or renewal payment is appropriate.

Compensation Payment Requirements

Plans/Part D Sponsors have the flexibility to make compensation payments annually, quarterly, monthly, or by a different schedule.

- **Compensation payments must be paid during the year of enrollment.**
- **Enrollments during the preceding year for effective dates January 1 (or later) of the following year, should not be compensated until January 1 or after.**
- **Payments for enrollments effective at any point during a calendar year must be paid in full by December 31 of the calendar year of enrollment.**
- **Compensation payments should be based on the number of months a beneficiary is enrolled during a calendar year.**

- Referral fees paid to agents must be part of total compensation, not to exceed the FMV for initials and 50% of FMV for referrals.
- Plans/Part D Sponsors that contract with third-parties to sell MA/Part D products must ensure that compensation payments to these third-parties are no greater than the Plans'/Part D sponsors' initial and renewal compensation amounts.

Compensation Payment Requirements

Full or pro-rated initial compensation may be paid to agent/brokers under the following three scenarios:

1. The beneficiary's first year of enrollment in an MA plan or MA-PD plan;
2. When a beneficiary enrolls in an "unlike plan type," during their renewal year; or
3. When a beneficiary moves from an employer group plan to a non-employer group plan (either within the same parent organization or between parent organizations) counts as an initial enrollment.

Renewal compensation may be paid to agents/brokers under the following three scenarios:

1. Following the initial year compensation;
2. When a beneficiary enrolls in a new "like plan" within the same Parent Organization or between two different Parent Organizations; or
3. When a beneficiary enrolled in an MMP switches to an MA plan or an MA-PD plan (and vice versa), if applicable per state MMP policy.

Compensation Payment Requirements

Initial compensation must be pro-rated to agents/brokers under the following scenario:

- When a beneficiary changes plans during their initial enrollment: The compensation payment is based on the number of months the beneficiary was enrolled in the plan. For example, if an initial enrollment changes from one parent organization to another parent organization for a May 1 effective date, the new parent organization must pay 8/12ths of the initial compensation to the agent/broker.

Other compensation scenarios are highlighted below:

- Either an initial compensation or a pro-rated compensation should be paid when a beneficiary enrolls in a plan and has no prior plan history. If the pro-rated compensation is used, it should be based on the number of months the beneficiary is enrolled.
- Only the MA compensation amount should be paid when a beneficiary enrolls in an MA-PD plan, not the MA compensation amount and the PDP compensation amount.
- When a beneficiary enrolls in both a section 1876 cost plan and a stand-alone PDP, compensation should be paid for both enrollments).

Compensation Recovery Requirements (Charge-Backs)

Plans/Part D Sponsors must recover compensation payments from agents/brokers under two circumstances:

1. When a beneficiary disenrolls from a plan within the first three months of enrollment (rapid disenrollment); and
2. Any other time a beneficiary is not enrolled in a plan but the Plan Sponsor had paid compensation for that time period.

Rapid Disenrollment

- Rapid disenrollment applies when an enrollee moves from one parent organization to another parent organization, or when an enrollee moves from one plan to another plan within the same parent organization within the first 3 months of enrollment.
- Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year during the Annual Election Period. If, however, a beneficiary enrolls in October and disenrolls in December, the Plan/Part D Sponsor should recover compensation based on the rapid disenrollment.

Compensation Recovery Requirements (Charge-Backs)

Rapid Disenrollment (Continued)

Rapid disenrollment compensation recovery does not apply when CMS determines that recoupment is not in the best interests of the Medicare program. Such situations include when a beneficiary disenrolls within the first three months for any of the following reasons:

- Other creditable coverage
- Gains/drops employer/union sponsored coverage
- Plan terminations and non-renewals
- In order to coordinate with an State Pharmaceutical Assistance Program (SPAP)
- Qualifying for another plan based on special needs
- Qualifying for another plan based on a chronic condition
- Death
- Non-payment of premium
- Retroactive notice of Medicare entitlement
- Moving into or out of an institution
- CMS sanction against the plan/contract violation
- In order to coordinate with Part D enrollment periods
- When moving to a plan with a 5-star rating or from a low performing plan into a plan with three or more stars
- Becoming LIS eligible
- Due to an auto, facilitated, or passive enrollment
- Moves out of the service area
- Loss of entitlement
- Dual eligibles moving from an MA to MMP

Recovering Compensation Payments (Charge-Backs)

Other Compensation Recovery

- Plans/Part D Sponsors must recover a pro-rated amount of initial compensation when an enrollee disenrolls from a plan. The amount recovered must be equal to the number of months not enrolled. For example, an enrollee ages in effective April 1. The enrollee disenrolls effective September 30 of the same year. The plan initially paid a full initial compensation. Since the enrollee disenrolled (not a rapid disenrollment), the Plan/Part D Sponsor must recover from the agent or broker 6/12ths of the initial compensation (January through March and October through December).
- Plans/Part D Sponsors must recover a pro-rated amount of renewal compensation when an enrollee disenrolls from a plan. This amount must be equal to the number of months not enrolled. For example, a renewal enrollee disenrolls effective February 28. The Plan/Part D Sponsor must recover from the agent or broker 10/12ths of the renewal payment if the renewal payment had been paid for the entire 12-month period.

Recovering Compensation Payments (Charge-Backs)

Other Compensation Recovery (continued)

- Plans/Part D Sponsors have the option to pay the agent or broker either full or pro-rated compensation for initial enrollments that are effective later than January 1 and the enrollees have no prior plan history. However, if the Plan/Part D Sponsor pays a full initial compensation and the enrollee disenrolls during the contract year, the Plan/Part D Sponsor must recoup a pro-rated amount for all months the beneficiary is not enrolled. This would include months prior to the enrollment. For example, a beneficiary ages into Medicare and elects an MA-PD plan (Plan A), effective April 1. The beneficiary moves and is eligible for a special enrollment period. The beneficiary elects a new MA-PD (Plan B), effective November 1. Plan A must recoup 5/12ths of the initial compensation (January through March and November through December) to account for the months the beneficiary was not enrolled in Plan A. Since the beneficiary had prior plan history when enrolled in Plan B, Plan B may only pay a pro-rated initial compensation equal to 2/12ths (November through December).
- Plans/Part D Sponsors must recover from the agent or broker a pro-rated amount of compensation when there is a “like plan change” from an MA or MA-PD to MMP. Compensation is not to be paid by the MA or the MA-PD plan for the months the member is in the MMP for that compensation cycle year. For example, a renewal enrollee makes a “like plan type” change from an MA to MMP effective July 1 of the compensation cycle year. The MA Plan must recover 6/12ths of the renewal payment.

Other Compensation and Additional Marketing Fees

Payments Other than Compensation

Payments made to third parties for services other than enrollment of beneficiaries (e.g., training, customer service, or agent recruitment) must not exceed FMV and must not exceed an amount that is commensurate with the amounts paid by the Plan/Part D Sponsor to a third party for similar services during each of the previous two (2) years.

Additional Marketing Fees

A Plan/Part D Sponsor may not charge a beneficiary or allow its marketing representatives to charge a beneficiary a marketing fee. All costs associated with the marketing of a plan are the responsibility of the Plan/Part D Sponsor.

Legal Representation

- If a potential beneficiary is unable to enroll him or herself into one of SilverScript's plan products, a family member can authorize the enrollment of the potential beneficiary only with written, legal documentation showing that the family member has the authority to act on the beneficiary's behalf.
- This legal representative must attest on the appropriate form that they have the authority to make healthcare decisions under the pertinent state law to effect the enrollment request on behalf of the beneficiary and that a copy of the documentation (e.g. a durable power of attorney or court-appointed guardianship) required by state law that evidences the representative's authority is available upon request.
- It is important to understand that you are not expected to be an expert on legal documentation. However, it is expected that you will use good professional judgment when working with a potential beneficiary and a family member or other party who is indicating that they have authority to act on the potential beneficiary's behalf.

SilverScript Auditing and Monitoring

As part of SilverScript's responsibility to monitor and oversee its marketing representatives' activities, periodic audits are conducted. The goals of these audits are:

- To review the marketing materials used in the solicitation and sales of our plan offerings.
- To monitor the marketing oversight activities of contracted national marketing organizations and the conduct of their marketing agents, as well as agents employed by CVS Health.

Audits may include:

- Review of agent licensure, training and certification.
- Review of compensation, system access and reporting.
- Review of material being used for marketing purposes to be sure it is all CMS-approved.

SilverScript is required to conduct outbound education and verification efforts to beneficiaries to ensure that the beneficiary understands the plan rules. For enrollments through a marketing representative, we will ensure that the marketing activity was conducted in accordance within CMS regulations.

CMS Auditing and Monitoring

In addition to SilverScript audits, CMS conducts audits throughout the year using several mechanisms to ensure marketing agent compliance, including:

- Prospective and retrospective review of marketing materials to ensure that they were approved by CMS.
- Marketplace surveillance of agent activities.
- Partnership with states' departments of insurance and beneficiary advocates, such as the National Association of Insurance Commissioners (NAIC).
- Secret shopping by CMS representatives.
- Monitoring marketing activity complaints and issues using the CMS compliant tracking module (CTM).
- Attendance of marketing/sales events.

Disciplinary Action

Current SilverScript policy provides for the immediate termination of an agent's contract to market SilverScript upon evidence of a violation of any law, regulation, or CMS guidance regarding the marketing or distribution of Medicare products.

CMS has the authority to levy a financial penalty for each beneficiary affected, or likely to be affected, by each violation.

Your Disclosure Requirement

It is your obligation to disclose to a potential beneficiary that you are contracted with SilverScript to market the plan offerings and that you may be compensated based on the beneficiary's enrollment.

- In doing so, you must not withhold, dilute or minimize the fact that you are compensated based on enrollment in the plan.
- You are required to disclose this information to the potential beneficiary in writing either prior to, or at the time of their enrollment – not after the beneficiary has enrolled.
- You MUST disclose all relevant aspects of SilverScript's products that you are marketing.
    - However, never disclose more than you know.
    - If you are unsure of an answer to a question, it is important not to provide a response that could be incorrect. In doing so, you could give the potential beneficiary the impression that you are misrepresenting the facts. Instead, tell the beneficiary that you will get back to him or her as soon as possible with answers to the requested information.

Best Practices

- Training on and understanding of CMS Marketing Guidelines, federal laws and statues, regulatory compliance and the consequences of violating these regulations is a CMS requirement.
- It can also go a long way to ensure that you are providing accurate and complete information to a potential beneficiary so that they can make an informed decision on the prescription drug plan that best suits their needs.
- Compliance also recommends the best practice guidelines that are provided in the following slides.

Give a Copy/Make a Copy/Keep a Copy

When you are showing/using documents to/with a potential beneficiary:

- You must give them every document defined in the enrollment kit.
- You must give them a copy of every document that they sign.
- It is in your best interest to make a copy of each document that you have a potential beneficiary sign and keep the copy in a file designated solely for that beneficiary.

In this way, you can help ensure that there should be no confusion as to what information was provided to the beneficiary during your initial and subsequent meetings and presentations.

Dot the “i” and Cross the “t”

- Dealing with potential beneficiaries requires special skills, patience and knowledge. Equally important, it requires you to be very precise with the information that you provide them whether written or verbally.
- Double check everything that you do. While this might be an arduous task, it is one that will help keep you in compliance.
- Ensure that your potential beneficiary understands the product offering. If there is any doubt, review the material again. Be sure to cover any and all items relevant to the transaction.

Your Reporting Obligations

- You are required to report any suspected non-compliance and/or fraud, waste or abuse with any of CMS's and/or SilverScript's rules and regulations as soon as you become aware of it. You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.
- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to any resources available to you as outlined in the next slide.

Compliance Resources

Feel free to contact the SilverScript Medicare Part D Compliance department if you are unsure of the answer to a question, want verification on a process, or need some direction on a compliance topic.

The CVS Health Ethics Line:

(877) CVS-2040 or Ethics.BusinessConduct@cvs.com

Patrick Jeswald, Chief Compliance Officer, SilverScript, Medicare Part D

480-661-2030 or Patrick.Jeswald@caremark.com

William Will, Director, Compliance / Fraud, Waste & Abuse

480-661-2383 or William.Will@CVSHealth.com

Summary

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

This section was designed to provide you with an overview of marketing guidance. Other modules address Medicare basics and beneficiary protections, enrollment, and product-specific details.

WARNING!

You are about to begin the knowledge assessment.

DO NOT use your internet browser's back button or right click to back up to the previous screen.

ONLY use the navigation arrows at the right of each test question. The use of the browser's back/forward buttons may cause errors in calculating your test score and this may lead to your failing the test.

Remember, you only have 3 attempts to pass each course.

Agent/Broker
Compliance Course

Updated June 29, 2018

2019 Annual Certification

Welcome to SilverScript University

At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans.

CMS requires that marketing agents and brokers be tested annually on rules, regulations, and details about the products they sell.

To help you properly represent your agency and our products, we have developed a training & certification program.

- The program consists of several easy-to-follow online training courses.
- Each module presents information on a different subject, testing your knowledge along the way with questions on what you have learned.
- Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next course.

Welcome to SilverScript University

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

Course Objective

SilverScript markets its Prescription Drug Plans (PDPs) through a select group of insurance carriers and national marketing organizations. It also markets directly to Medicare beneficiaries who often call SilverScript for additional information and to enroll in its PDPs. As a SilverScript representative, you are obligated to:

- Abide by the rules, regulations and guidance issued by CMS.
- Abide by HIPAA and state privacy laws.
- Abide by the policies, procedures and guidelines issued by SilverScript.

At the completion of this training course, you should be familiar with the following:

- CMS Medicare Marketing Guidelines.
- HIPAA guidelines.
- SilverScript policies and procedures for agents/brokers.
- Your reporting obligations.

SilverScript & Medicare Part D

SilverScript contracts with CMS as plan sponsors to administer the Medicare Part D prescription drug benefit.

One aspect of our oversight program is to provide marketing representatives with proper training on how to comply with the Medicare Part D rules and regulations.

It is important that you understand and comply with guidelines as defined by CMS, HIPAA regulations, and SilverScript because:

- You are in a position to affect the decision of potential beneficiaries regarding their plan choice.
- You are held accountable for your activities in the Medicate Part D marketplace.
- SilverScript is ultimately responsible for your activities when representing our PDPs and Group products.

You are held accountable to comply with all Federal and State privacy and security laws.

Protected Health Information (PHI)

The HIPAA Privacy Rule standards address the use and disclosure of an individual's health information, called Protected Health Information (PHI). PHI is any information that can be used to identify an individual and that is obtained by or on behalf of a health plan or health care provider.

- The Privacy Rule protects all PHI held or transmitted in any form or media, whether electronic, paper or oral, by a covered entity (such as SSIC) or its business associate (such as you).
- PHI includes information that relates to:
    - The individual's past, present or future physical or mental health or condition.
    - The provision of health care to the individual.
    - The past, present, or future payment for the provision of health care to the individual.
    - Information that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual.
- Examples of PHI include demographic information with any health diagnoses, medications, Medicare or SSN numbers, names of doctors, dates of treatment, etc.

Health Insurance Portability Accountability Act (HIPAA)

HIPAA protects the privacy and security of personal health information and provides assurance to individuals that their personal health information will not be misused.

- HIPAA establishes standards for certain electronic transactions and minimum privacy and security requirements.
- Your obligations under HIPAA were defined in the Business Associates Agreement you signed at the time of contracting. In particular:
    - Use and disclose PHI only for purposes for which it was provided (i.e. marketing and enrollment in a SilverScript plan).
    - Use and disclose only the minimum necessary PHI for a particular task.
    - Always keep PHI secure (e.g. don't leave documents containing PHI on your desk when you go out, stand by the fax machine when expecting a fax with PHI if the fax machine is not in a secure area, don't send PHI unencrypted over public networks).
    - Always encrypt PHI when sending over public networks.

Anti-Kickback Statute

One important law that governs the behavior of marketing agents is the Anti-Kickback Statute.

- This law prohibits anyone from offering inducements to purchase or use health products or services if these products or services are reimbursable in whole or in part by the federal government.
- Importantly, a violation of this statue can result in exclusion from participation in the Medicare Part D program and other federal healthcare programs. In addition, this statute carries both civil and criminal penalties for violation.

CMS Regulations

One of the primary regulations that govern your activities as a Medicare Part D marketing agent is the Part D rule found in the Code of Federal Regulations (CFR) Title 42. Parts 422, 423 and 417.

- Each year CMS issues updates to the Prescription Drug Benefit Manual. The manual contains detailed operational guidance based on the governing law defined in CFR. The focus of this training course is on Medicare Marketing Guidelines (MMG) of the manual, "The Medicare Marketing Guidelines for Medicare Advantage plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and 1876 Cost Plans."
- The following slides describe the do's and don'ts for your marketing activities as described in MMG of the Prescription Drug Benefit Manual.

Marketing and Sales Oversight

Marketing includes any activity of an employee of a plan sponsor, an independent agent, or an independent broker or any other person that acts on a plan sponsor's behalf to affect a beneficiary's choice among Medicare plans

- Marketing by a person who is directly employed by an organization with which a plan sponsor contracts to perform marketing or a downstream marketing contractor is considered marketing by the plan sponsor
- You may not charge a beneficiary a marketing fee or any other fee. The only amount that the beneficiary is required to pay is the plan's approved premium (which is to be paid directly to the plan), and the plan may use a portion of that to compensate a marketing representative. Agents are not permitted to collect premiums from beneficiaries.

Licensure and State Appointment Laws

Agents must be actively licensed in the beneficiary's state of residence at the time of the marketing activity and enrollment.

- The use of state-licensed marketing representatives helps ensure that:
    - A minimum standard of integrity and professionalism is displayed when marketing to Medicare-eligible beneficiaries; and
    - Medicare beneficiaries are not the victims of substandard or inappropriate marketing activities.
- In order to market SilverScript plan offerings, you must:
    - Be licensed in the state in which you conduct marketing activities;
    - Meet the necessary state educational requirements;
    - Be appointed by the plan in accordance with state appointment regulations; and
    - Obtain your training certification by passing the training modules at the required level (as described in the beginning of this module).
- In order to sell Medicare products, plan sponsors must comply with applicable State licensure and/or appointment laws.

Activities That Do Not Require the Use of State-Licensed Marketing Representatives

The following activities conducted by a plan customer service representative do not require the use of state-licensed marketing representatives, unless otherwise stated by state law. These include:

- Providing factual information;
- Fulfilling a request for materials;
- Taking demographic information in order to complete an enrollment application at the initiative of the prospective enrollee;
- “For-cause” review of materials and activities when complaints are made by any source, and CMS determines it is appropriate to investigate; and
- "Secret shopper” activities where CMS requests Plan/Part D Sponsor materials such as enrollment packets.

- However, if Plans/Part D Sponsors use licensed agents/brokers (employed or contracted) as customer service representatives, they cannot act as both a customer service representative and a sales/marketing agent/broker.

Plan Reporting of Terminated Agents

- Plan sponsors must immediately report the termination of any agents/brokers to the State (adhering to state requirements for reporting terminations to the state) and the reasons for the termination, if State law requires the reasons to be reported.
- Plan sponsors must report for-cause terminations to CMS Account Managers. Plan sponsors must also report to CMS Account Managers any sales of Medicare products which were made by agents without a valid license.

If a Plan sponsor discovers an enrollment application was submitted by an unlicensed agent or broker, the plan sponsor must immediately terminate the agent or broker and report this action to the State where the application was submitted.

- Additionally, plan sponsors must notify any beneficiaries who were enrolled by unqualified agents/brokers (e.g., unlicensed, not appointed, or has not completed the annual training/testing) and advise those beneficiaries of the agents'/brokers' status.
- Beneficiaries may request to make a plan change.

Background Check

SilverScript is required to screen all marketing representatives against the Department of Health and Human Services (DHHS) and Office of the Inspector General (OIG) Lists of Excluded Individuals & Entities. This is done to ensure that the marketing representatives are not excluded from participation in any federal health care programs.

Marketing representatives found to be on these lists are immediately barred from marketing SilverScript PDPs and sanctions will be imposed for failure to disclose this information. However, if after being barred, a marketing representative is reinstated, a monitoring plan will be established to ensure that future business submitted by the marketing representative will be scrutinized in order to mitigate the risk of future non-compliance.

Agent/Broker Training and Testing

- Plan sponsors must ensure that all agents/brokers (employed/captive or independent) selling Medicare products are trained and tested annually on Medicare rules, regulations, and on details specific to the plan products that they sell.

  This means that training and testing must take place prior to the broker/agent selling the product.

- CMS provides updated guidance annually for agents/brokers training/testing. Plan sponsors must ensure that their agents/brokers training/testing programs are designed and implemented in a way that maintains the integrity of the training and testing, and must have the ability to provide this information to CMS upon request.
- In order to sell SilverScript's Medicare products, a broker or agent must receive a passing score of at least 90% on each certification test.

Agent/Broker Use of Marketing Materials

- Plan sponsors are responsible for all marketing materials used by their subcontractors to market their plans. All marketing materials used by plan sponsors or their subcontractors must be submitted to CMS by the plan sponsor that contracts with CMS (e.g., SilverScript) for review and approval prior to use. Marketing materials cannot be submitted directly by a third party to CMS. It is the responsibility of plan sponsors to ensure that all applicable materials created by a third party meet the requirements outlined in CMS' current marketing regulations guidance.

Agents and brokers must submit marketing materials to SilverScript for review and approval prior to distributing any materials to prospects, clients or members.

- All marketing material must be approved by SilverScript and by CMS.

Marketing

The following materials, while not an exhaustive list, may fall under CMS' purview per the definition of marketing materials:

- General audience materials such as general circulation brochures, direct mail, newspapers, magazines, television, radio, billboards, yellow pages, or the internet
- Marketing representative materials such as scripts or outlines for telemarketing or other presentations
- Presentation materials such as slides and charts
- Promotional materials such as brochures or leaflets, including materials circulated by physicians, other providers, or third party entities
- Membership communications and communication materials including membership rules, subscriber agreements, enrollee handbooks and wallet card instructions to enrollees (e.g., Annual Notice of Change (ANOC), Evidence of Coverage (EOC), Provider/Pharmacy Directory)
- Communications to enrollees about contractual changes, and changes in providers, premiums, benefits, plan procedures
- Communications related to membership activities (e.g., materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or non-claim specific notification information)
- The activities of a plan sponsor's employees, independent agents or brokers, subcontracted Third Party Organizations (TMO) (downstream contractors), or other similar type organizations that contribute to the steering of a potential enrollee toward a specific plan or limited number of plans, or may receive compensation directly or indirectly from a plan sponsor for marketing activities

Required Materials in Pre-Enrollment Package

When beneficiaries are provided with plan-specific marketing information that includes an enrollment/instruction form, they must also receive the following materials:

- Plan ratings information which must be a standalone document
    - Updated plan rating documents are available shortly after CMS releases the plan year ratings.
        - Agents are expected to replace the out-dated document with the updated form that is available for download via the SilverScript Agent Portal.
        - SilverScript will include the updated document in all pre-enrollment kits once the forms are approved and ready for distribution.
- Summary of Benefits (SB)
- The pre-enrollment kits are available for order and for download via the SilverScript Agent Portal.

Required Materials for New Enrollees

The following documents must be provided to all new enrollees no later than 10 calendar days from the receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever is earlier. In addition, these materials must be made available upon beneficiary request.

- Comprehensive Formulary or Abridged Formulary
- Pharmacy Directory
- Membership ID Card
- New enrollees with an effective date of January 1 or later must receive an EOC for the contract year of coverage.
- A cover letter that includes the plan's toll-free customer service telephone number, a TTY telephone number, customer service hours of operation, and a physical or post office address is optional since the contact information is included in the SB.
- SilverScript mails the Welcome Kits directly to new enrollees.

Required Materials for New and Renewing Members

Plan sponsors must ensure that their current/renewing members receive the Annual Notice of Change/Evidence of Coverage (ANOC/EOC) accompanied by the Low Income Subsidy (LIS) Rider no later than September 30th of each year.

New Enrollees with an effective date of November 1st or December 1st should receive both an EOC for the current contract year and an ANOC/EOC for the upcoming contract year.

- Renewing members are required to receive the following materials:
    - Combined ANOC/EOC
    - Low Income Subsidy (LIS) Rider, if applicable
    - Comprehensive Formulary or Abridged Formulary including information on how the beneficiary can obtain a complete formulary
    - A hard copy pharmacy directory, or separate notice to alert enrollees where they can find the pharmacy directory online and how they can request a hard copy
    - Membership ID Card (required only if a change is required by plan sponsor post-enrollment)
- We automatically mail these items to members.
- Part D sponsors must ensure that enrollees who utilize their prescription drug benefits in a given month receive their Explanation of Benefits (EOB) by the end of the month following the month in which they utilized their prescription drug benefits.

Star Ratings Information

- The Medicare program rates how well plan sponsors perform in different categories.
- Plan performance summary star ratings are assessed each year and may change from one year to the next.
- Star Ratings are generally issued in October of each year. Plan sponsors will be required to use updated Star Ratings information within 21 calendar days of the release of the updated information.
- Plan sponsors must provide Star Ratings information to beneficiaries through the standardized Star Ratings information document.
    - The Star Ratings information document must be distributed when the SB and/or the enrollment form is provided to beneficiaries.
- The Star Ratings information document must also be prominently posted on plan websites.
- Plan Sponsors are not permitted to display or release their Star Ratings information until CMS releases the Star Ratings on Medicare Plan Finder (MPF).

General Guidance about Promotional Activities

Promotional activities must comply with all relevant Federal and State laws.

- Plan sponsors may be subject to compliance and/or enforcement actions if they offer or give something of value to a Medicare beneficiary that the plan sponsor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare.
- Marketing representatives must clearly identify the types of products that will be discussed before marketing to a potential enrollee. This includes all sales presentations, events, appointments, and outbound calls that are designed to promote or encourage a beneficiary to enroll in a plan. Additionally, plan sponsors are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.
- Furthermore, plan sponsors are prohibited from offering or giving remuneration to induce the referral of a Medicare beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare program.

Marketing in a Health Care Setting

Marketing representatives may not conduct sales activities in healthcare settings except in common areas.

- Common areas where marketing activities are allowed include areas such as common entryways, vestibules, hospital or nursing home cafeterias, community, recreational, or conference rooms.
- If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services from or interact with pharmacy providers and obtain medications.

- Marketing representatives are prohibited from:
  - Conducting sales presentations, distributing and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily receive health care services or are waiting to receive health care services.
    - These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).
    - The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

Marketing in a Health Care Setting

- Agents are only permitted to schedule appointments with beneficiaries residing in long-term care facilities (including nursing homes, assisted living facilities, board and care homes, etc.) upon request by the beneficiary.
- Plan sponsors may use providers and/or facilities to distribute and/or make available plan marketing materials as long as the provider and/or the facility distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, a plan sponsor must only ensure that a provider/facility agrees to make available and/or distribute plan marketing materials and accept future requests from other plan sponsors with which the provider/facility participates. Plan sponsors may also provide materials for a provider's/facility's common area, such as the waiting room. Additionally, plan sponsors may provide long-term care facilities with materials for admission packets announcing all plan contractual relationships.
- Institutional Special Needs Plans (I-SNPs) are permitted to provide long term care facility staff with an I-SNP explanatory brochure to distribute to residents who meet the I-SNP criteria for enrollment. The brochure may explain the qualification criteria and the benefits of being enrolled in an ISNP. The brochure may have a reply card or telephone number for the resident, or responsible party, to call to request a meeting or additional information.

General Guidance about Promotional Items

Generally, promotional activities are designed to attract the attention of prospective enrollees and/or encourage retention of current enrollees. In addition to the guidance on nominal gifts, any promotional activities or items offered by plan sponsors must:

- Have only nominal value (be worth no more than $15) based on the fair market value of the item or less, with a maximum aggregate of $75 per person, per year.
- Be offered to all potential enrollees regardless of whether they enroll, and without discrimination.
- Not be items that are considered a drug/health benefit including optional mandatory supplemental benefits (e.g., a free checkup); and
- Not be tied directly or indirectly to the provision of any other covered item or service.

Note: plan sponsors should track and document items given to current enrollees. Plan sponsors are not required to track pre-enrollment promotional items on a per person basis; however, they may not willfully structure pre-enrollment activities with the intent to give people more than $75 per year.

Nominal Gifts

Plan sponsors may offer gifts to potential enrollees, as long as those gifts are of nominal value, provided regardless of enrollment, and without discrimination.

- The following rules must be followed when providing nominal gifts:
    - If a nominal gift is one large gift (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per-person value based on attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). For planning purposes, anticipated attendance may be used, but must be based on actual venue size, response rate, or advertisement circulation.
    - Nominal gifts may not be in the form of cash or other monetary rebates, even if their worth is $15 or less. Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.

Exclusion of Meals as a Nominal Gift

- Plan sponsors may not provide or subsidize meals at sales/marketing events.
- Plan sponsors may provide refreshments and light snacks.
- Plan sponsors should use their best judgment on the appropriateness of food products provided, and should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal.
- Meals may be provided at educational events, provided the event meets CMS’ strict definition of an educational event, and complies with the nominal gift requirement in regulations.

Unsolicited Electronic Communication Policy

- A plan sponsor may initiate separate electronic contact.
- Plan sponsors must provide an opt-out process for enrollees to no longer receive email or other electronic communications.
- Plan sponsors are prohibited from renting or purchasing email lists to distribute information about MA, PDP, or section 1876 cost plans, and may not send electronic communications to individuals at email addresses or on social media obtained through friends or referrals.

Marketing through Unsolicited Contacts

In general, plan sponsors may not market through unsolicited contacts, including but not limited to:

- Door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence or car.
- Approaching beneficiaries in common areas, (e.g., parking lots, hallways, lobbies, sidewalks, etc.).

  NOTE: Agents/brokers who have a pre-scheduled appointment that becomes a “no-show” may leave information at the no-show beneficiary’s/individual's residence.

- The prohibition on marketing through unsolicited contacts does not extend to conventional mail and other print media (e.g., advertisements, direct mail).
- In addition, permission given to be called or otherwise contacted must be event-specific, and may not be treated as open-ended permission for future contacts.

Rules for Telephonic Contact

Agents may contact their own clients and plan sponsors may contact current enrollees at any time to discuss plan business. Prohibited telephonic activities include, but are not limited to, the following:

- Bait-and-switch strategies - making unsolicited calls about other business as a means of generating leads for Medicare plans
- Calls based on referrals - if an individual would like to refer a friend or relative to an agent or plan sponsor, the agent or plan sponsor may provide contact information such as a business card that the individual may give to a friend or relative. Otherwise, a referred individual needs to contact the plan or agent/broker directly.
- Calls to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling (except as permitted on the next page), to market plans or products. Enrollees 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.
- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (the plan sponsor must have documentation of permission to be contacted).
- Calls to beneficiaries to confirm receipt of mailed information, except as permitted on the next page.

Rules for Telephonic Contact

Plan sponsors may conduct the following activities:

- Call beneficiaries who submit enrollment applications to conduct quality control and/or agent/broker oversight activities.
- Call their current MA and non-MA enrollees 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.
- Call their current MA enrollees to promote other Medicare plan types or to discuss plan benefits (e.g., sponsors may contact their PDP members to promote their MA-PD offerings; Plans/Part D Sponsors that are also Medigap issuers may market their MA, PDP, or cost plan products to their Medigap enrollees).
- Call their current enrollees, 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.

Rules for Telephonic Contact

Plan sponsors may conduct the following activities:

- Call their enrollees to conduct normal business related to enrollment in the plan, including calls to enrollees who have been involuntarily disenrolled to resolve eligibility issues.
- Call former enrollees after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Disenrollment surveys may be conducted telephonically or mailed. Surveys conducted in either manner may not include sales or marketing information.
- Under limited circumstances and subject to advance approval from the appropriate CMS Account Manager, call LIS-eligible enrollees 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 (BRC), sending an email to the Plan Sponsor requesting a return call, or asking a customer service representative (CSR) 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 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.

Enrollment Verification Requirements

- Plan sponsors are required to maintain a system to ensure beneficiaries are enrolled into the plan they requested and understand the rules applicable to that plan. This system must be maintained for all agent/broker assisted enrollments, including enrollment requests in which an independent or employed agent/broker provided plan-specific information to the individual, thus potentially influencing the individual's plan choice and/or assisting in a subsequent enrollment request.
- Plan sponsors have the option to complete the enrollment verification process by telephone, email (if beneficiary opted-in for email) or direct mail. The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request.
- Plan sponsors may integrate the enrollment verification process into an existing practice, such as welcome calls, without making a separate call for enrollment verification. If the plan sponsor chooses to utilize a telephonic contact but is unable to speak with the individual or his or her appointed/authorized representative directly, the plan sponsor must either continue call attempts or follow up with a written communication. The Plan Sponsor must document the timing and method of contact.

Enrollment Verification Requirements

Enrollment verification is expected to be made to the applicant after the sale has occurred and not at the point of sale. The plan sponsor is expected to ensure that enrollment verifications are not conducted by sales agents. Also, if calling or emailing applicants, plan sponsors are expected to ensure that sales agents are not physically present with the applicant at the time of the verification. The following agent/broker-assisted enrollments are excluded from the OEV requirement:

- Enrollments into employer or union sponsored plans
- 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)

Prospective Enrollee Educational Events

- An educational event is an event designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and does not include marketing (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans). Educational events may be hosted by the plan sponsor or an outside entity and are held in a public venue. These events cannot be held at in-home or one-on-one settings.
- Educational events for prospective enrollees may not include any sales activities including the distribution of marketing materials or the distribution/collection of plan applications. This includes the distribution of any material with plan-specific information (including plan-specific premiums, co-payments, or contact information). Educational events must be explicitly advertised as "educational," otherwise they will be considered by CMS as sales/marketing events.
- The intent of this guidance is not to preclude plan sponsors from informing beneficiaries about their products; rather, it is to ensure that events that are advertised as "educational" are only educational and comply with CMS' requirements. More specifically, plan sponsors may provide education at a sales or marketing event, but may not market or sell at an educational event.

Prospective Enrollee Educational Events

The following are examples of acceptable materials and activities by Plans/Part D Sponsors or their representatives at an educational event:

- A banner with the plan name and/or logo displayed
- 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.
- Responding to questions asked at an educational event

Prospective Enrollee Educational Events

At educational events, Plans/Part D Sponsors or their representatives may not:

- Discuss plan-specific premiums and/or benefits.
- Distribute plan-specific materials.
- Distribute or display business reply cards, scope of appointment forms, enrollment forms, or sign-up sheets.
- Set up individual sales appointments or get permission for an outbound call to the beneficiary.
- Attach business cards or plan/agent contact information to educational materials, unless requested by the beneficiary.
- Advertise an educational event and then have a marketing/sales event immediately following in the same general location (e.g., same hotel).

- These activities constitute prohibited sales activities at educational events.

Marketing/Sales Events and Appointments

Marketing/sales events are events designed to steer, or attempt to steer, potential enrollees toward a plan or limited set of plans. At marketing/sales events, plan representatives may discuss plan specific information and collect applications.

Plan sponsors must submit all sales scripts and presentations for approval to CMS prior to their use during the marketing/sales event.

Marketing/Sales Events and Appointments

At a marketing/sales event, Plans/Part D Sponsors may not:

- Conduct health screening or other like activities that could give the impression of “cherry picking.”
- Require beneficiaries to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through mail. Plan sponsors should clearly indicate on any sign-in sheets that completion of any contact information is optional.
- Use personal contact information obtained to notify individuals of raffle or drawing winnings for any other purpose.

Notifying CMS of Scheduled Marketing Events

Agents must notify SilverScript of all marketing/sales events prior to advertising the event or 7 calendar days prior to the event's scheduled date, whichever is earlier. For detailed instructions, including the earliest upload date, please refer to the Agent Portal Reference Materials tab.

- **We ask that agents submit the required information (i.e. time, date and place) about the event to SilverScript no later than 10 days preceding the event or before it is advertised, whichever is earlier.**
- **Email event information to ProducerSalesResource@cvscaremark.com.**
- In some situations, you will be able to schedule an event with less than 10 days advanced notice. Contact SilverScript as soon as you confirm an event.

- Changes to marketing/sales events, (e.g., cancellations and room changes), must be communicated to SilverScript at least 48 hours prior to the scheduled event.

Personal/Individual Marketing Appointments

All plan sponsor one-on-one appointments with beneficiaries, regardless of the venue (e.g., in home, conference call, library), are considered sales/marketing events and must follow the scope of appointment (SOA) guidance.

- The plan sponsor's representative may not do the following:
  - Discuss plan options that were NOT agreed to by the beneficiary.
  - Market non-health care related products (such as annuities or life insurance).
  - Ask a beneficiary for referrals.
  - Solicit/accept an enrollment request (application) for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.

Scope of Appointments

- When conducting marketing activities, a plan sponsor's agent/broker may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed to before the meeting. The Plan Sponsor must document the scope of the appointment prior to the appointment.
- Distinct lines of plan business include MA, PDP and Cost Plan products. If the agent/broker would like to discuss additional products during the appointment in which the beneficiary indicated interest, but did not agree to discuss in advance, the agent/broker must document a second scope of appointment (SOA) for the additional product type to continue the marketing appointment.

Scope of Appointments

To further clarify the requirements around documentation:

- SilverScript requires that the Scope of Appointment documentation be in writing. (The exception to this SilverScript policy is call center-based organizations. These entities are required to capture recorded oral agreements).
- Other plan sponsors may allow a variety of technological means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes, and e-mail, etc; however, SilverScript does not allow these other methods.
- A beneficiary may set a scope of appointment at a marketing/sales event for a future appointment.

Scope of Appointments

The written Scope of Appointment (SOA) must include the following:

- 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 Medicare enrollment status will not be impacted.
    - The beneficiary is not automatically enrolled in the plan(s) discussed.

Beneficiary Walk-ins

Beneficiary Walk-ins to a Plan at Agent/Broker Office or Similar Beneficiary-Initiated Face-to-Face Sales

- In instances where a beneficiary visits an agent/broker office on his/her own accord, the plan sponsor or agent/broker must document the scope of appointment prior to discussing MA, PDP, or cost plans.

General Rules Regarding Compensation

All compensation requirements contained in this section apply to independent agents/brokers. Employed and captive agents/brokers who only sell for one Plan/Part D Sponsor are exempt from compensation requirements, except where noted (e.g., referral/finder fees). However, all other marketing and sales requirements must be met.

- Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fee.
- Compensation DOES NOT include:
    - The payment of fees to comply with state appointment laws;
    - Training;
    - Certification;
    - Testing costs;
    - Reimbursement for mileage to, and from, appointments with beneficiaries; or
    - Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

General Rules Regarding Compensation

Initial compensation may be paid at or below the fair market value (FMV) cut-off amounts published by CMS annually.

Renewal compensation may be paid for each enrollment in year 2 and beyond. Renewal compensation may be paid up to fifty (50) percent of the current FMV, published by CMS annually.

Referral/Finder's fees paid to agents and brokers, including independent, employed, and captive agents and brokers, may not exceed $100 ($25 for PDPs).

- This amount is not reasonably expected to provide enough financial incentive for an agent or broker to recommend or enroll a beneficiary into a plan that is not the most appropriate for the beneficiary's needs.
- Additionally, referral/finder's fees paid to all agents and brokers must be part of total compensation and must not exceed FMV for that contract year.

Enrollment Types for Compensation Purposes

A “like plan type” enrollment includes:

- A PDP to another PDP.
- An MA, MA-PD, or MMP to another MA, MA-PD, or MMP.
- A section 1876 cost plan to another section 1876 cost plan.

An “unlike plan type” enrollment includes:

- An MA or MA-PD plan to a PDP or section 1876 cost plan.
- A PDP to a section 1876 cost plan or an MA (or MA-PD) plan.
- A section 1876 cost plan to an MA (or MA-PD) plan or PDP.

Note: For dual enrollments (e.g., enrollment in an MA-only plan and a stand-alone PDP), the compensation rules apply independently to each plan. However, when dual enrollments are replaced by an enrollment in a single plan, compensation is paid based on the MA movement (e.g., movement from an MA-only plan and PDP to an MA-PD plan would be compensated at the renewal compensation amount for the MA to MA-PD “like plan type” move).

General Rules Regarding Compensation

- Plans/Part D Sponsors may not pay compensation to agents/brokers who have not been trained and tested, do not meet state licensure/appointment requirements or those who have been terminated for cause.
- When a Plan/Part D Sponsor and/or a contracted independent agent/broker terminates an agent/broker contract, any future payment of existing business will be governed by the terms of the contract, subject to the limits in the regulation.
- Note: Non-agents/brokers receiving referral fees are not subject to the general compensation rules (e.g., training/testing/licensure).

Compensation Payment Requirements

- Each year, Plans/Part D Sponsors may decide whether they are using employed, captive, and/or independent agents, as well as the amount within CMS' FMV limits they will compensate independent agents/brokers.
- Each year, CMS issues an HPMS memo that notifies Plans/Part D Sponsors of the FMV, and requires them to inform CMS yearly by the end of July whether they will use agents/brokers, including the types of agents/brokers, as well as the compensation payment ranges. Once the July deadline has passed, Plans/Part D Sponsors may not change what they submitted and attested to.
- In addition, Plans/Part D Sponsors must have in place their full agent/broker compensation structure for new and renewal enrollments by October 1 each year.
    - This structure supports the compensation payment ranges submitted earlier in the year and must be made available to CMS upon request.
    - The compensation structure includes how the Plan/Part D Sponsor plans to disseminate compensation to the agent/broker.
- **The agent/broker compensation year is January 1 to December 31.**
    - Compensation payments must be calculated on a January to December enrollment year.
    - They may not be made on a rolling basis or on an enrollment year based on the initial enrollment month.
    - For example, if a beneficiary's enrollment is effective September 1, then the initial enrollment year for that beneficiary ends on December 31 and the beneficiary's "renewal" year would begin in January of the following year.
    - Plans/Part D Sponsors should consult the MARx agent/broker compensation report to determine whether an initial or renewal payment is appropriate.

Compensation Payment Requirements

Plans/Part D Sponsors have the flexibility to make compensation payments annually, quarterly, monthly, or by a different schedule.

- **Compensation payments must be paid during the year of enrollment.**
- **Enrollments during the preceding year for effective dates January 1 (or later) of the following year, should not be compensated until January 1 or after.**
- **Payments for enrollments effective at any point during a calendar year must be paid in full by December 31 of the calendar year of enrollment.**
- **Compensation payments should be based on the number of months a beneficiary is enrolled during a calendar year.**

- Referral fees paid to agents must be part of total compensation, not to exceed the FMV for initials and 50% of FMV for referrals.
- Plans/Part D Sponsors that contract with third-parties to sell MA/Part D products must ensure that compensation payments to these third-parties are no greater than the Plans'/Part D sponsors' initial and renewal compensation amounts.

Compensation Payment Requirements

Full or pro-rated initial compensation may be paid to agent/brokers under the following three scenarios:

1. The beneficiary's first year of enrollment in an MA plan or MA-PD plan;
2. When a beneficiary enrolls in an "unlike plan type," during their renewal year; or
3. When a beneficiary moves from an employer group plan to a non-employer group plan (either within the same parent organization or between parent organizations) counts as an initial enrollment.

Renewal compensation may be paid to agents/brokers under the following three scenarios:

1. Following the initial year compensation;
2. When a beneficiary enrolls in a new "like plan" within the same Parent Organization or between two different Parent Organizations; or
3. When a beneficiary enrolled in an MMP switches to an MA plan or an MA-PD plan (and vice versa), if applicable per state MMP policy.

Compensation Payment Requirements

Initial compensation must be pro-rated to agents/brokers under the following scenario:

- When a beneficiary changes plans during their initial enrollment: The compensation payment is based on the number of months the beneficiary was enrolled in the plan. For example, if an initial enrollment changes from one parent organization to another parent organization for a May 1 effective date, the new parent organization must pay 8/12ths of the initial compensation to the agent/broker.

Other compensation scenarios are highlighted below:

- Either an initial compensation or a pro-rated compensation should be paid when a beneficiary enrolls in a plan and has no prior plan history. If the pro-rated compensation is used, it should be based on the number of months the beneficiary is enrolled.
- Only the MA compensation amount should be paid when a beneficiary enrolls in an MA-PD plan, not the MA compensation amount and the PDP compensation amount.
- When a beneficiary enrolls in both a section 1876 cost plan and a stand-alone PDP, compensation should be paid for both enrollments).

Compensation Recovery Requirements (Charge-Backs)

Plans/Part D Sponsors must recover compensation payments from agents/brokers under two circumstances:

1. When a beneficiary disenrolls from a plan within the first three months of enrollment (rapid disenrollment); and
2. Any other time a beneficiary is not enrolled in a plan but the Plan Sponsor had paid compensation for that time period.

Rapid Disenrollment

- Rapid disenrollment applies when an enrollee moves from one parent organization to another parent organization, or when an enrollee moves from one plan to another plan within the same parent organization within the first 3 months of enrollment.
- Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year during the Annual Election Period. If, however, a beneficiary enrolls in October and disenrolls in December, the Plan/Part D Sponsor should recover compensation based on the rapid disenrollment.

Compensation Recovery Requirements (Charge-Backs)

- Other creditable coverage
- Gains/drops employer/union sponsored coverage
- Plan terminations and non-renewals
- In order to coordinate with an State Pharmaceutical Assistance Program (SPAP)
- Qualifying for another plan based on special needs
- Qualifying for another plan based on a chronic condition
- Death
- Non-payment of premium
- Retroactive notice of Medicare entitlement
- Moving into or out of an institution
- CMS sanction against the plan/contract violation
- In order to coordinate with Part D enrollment periods
- When moving to a plan with a 5-star rating or from a lov plan into a plan with three or more stars
- Becoming LIS eligible
- Due to an auto, facilitated, or passive enrollment
- Moves out of the service area
- Loss of entitlement
- Dual eligibles moving from an MA to MMP

Rapid Disenrollment (Continued)

Rapid disenrollment compensation recovery does not apply when CMS determines that recoupment is not in the best interests of the Medicare program. Such situations include when a beneficiary disenrolls within the first three months for any of the following reasons:

Recovering Compensation Payments (Charge-Backs)

Other Compensation Recovery

- Plans/Part D Sponsors must recover a pro-rated amount of initial compensation when an enrollee disenrolls from a plan. The amount recovered must be equal to the number of months not enrolled. For example, an enrollee ages in effective April 1. The enrollee disenrolls effective September 30 of the same year. The plan initially paid a full initial compensation. Since the enrollee disenrolled (not a rapid disenrollment), the Plan/Part D Sponsor must recover from the agent or broker 6/12ths of the initial compensation (January through March and October through December).
- Plans/Part D Sponsors must recover a pro-rated amount of renewal compensation when an enrollee disenrolls from a plan. This amount must be equal to the number of months not enrolled. For example, a renewal enrollee disenrolls effective February 28. The Plan/Part D Sponsor must recover from the agent or broker 10/12ths of the renewal payment if the renewal payment had been paid for the entire 12-month period.

Recovering Compensation Payments (Charge-Backs)

Other Compensation Recovery (continued)

- Plans/Part D Sponsors have the option to pay the agent or broker either full or pro-rated compensation for initial enrollments that are effective later than January 1 and the enrollees have no prior plan history. However, if the Plan/Part D Sponsor pays a full initial compensation and the enrollee disenrolls during the contract year, the Plan/Part D Sponsor must recoup a pro-rated amount for all months the beneficiary is not enrolled. This would include months prior to the enrollment. For example, a beneficiary ages into Medicare and elects an MA-PD plan (Plan A), effective April 1. The beneficiary moves and is eligible for a special enrollment period. The beneficiary elects a new MA-PD (Plan B), effective November 1. Plan A must recoup 5/12ths of the initial compensation (January through March and November through December) to account for the months the beneficiary was not enrolled in Plan A. Since the beneficiary had prior plan history when enrolled in Plan B, Plan B may only pay a pro-rated initial compensation equal to 2/12ths (November through December).
- Plans/Part D Sponsors must recover from the agent or broker a pro-rated amount of compensation when there is a “like plan change” from an MA or MA-PD to MMP. Compensation is not to be paid by the MA or the MA-PD plan for the months the member is in the MMP for that compensation cycle year. For example, a renewal enrollee makes a “like plan type” change from an MA to MMP effective July 1 of the compensation cycle year. The MA Plan must recover 6/12ths of the renewal payment.

Other Compensation and Additional Marketing Fees

Payments Other than Compensation

Payments made to third parties for services other than enrollment of beneficiaries (e.g., training, customer service, or agent recruitment) must not exceed FMV and must not exceed an amount that is commensurate with the amounts paid by the Plan/Part D Sponsor to a third party for similar services during each of the previous two (2) years.

Additional Marketing Fees

A Plan/Part D Sponsor may not charge a beneficiary or allow its marketing representatives to charge a beneficiary a marketing fee. All costs associated with the marketing of a plan are the responsibility of the Plan/Part D Sponsor.

Legal Representation

- If a potential beneficiary is unable to enroll him or herself into one of SilverScript's plan products, a family member can authorize the enrollment of the potential beneficiary only with written, legal documentation showing that the family member has the authority to act on the beneficiary's behalf.
- This legal representative must attest on the appropriate form that they have the authority to make healthcare decisions under the pertinent state law to effect the enrollment request on behalf of the beneficiary and that a copy of the documentation (e.g. a durable power of attorney or court-appointed guardianship) required by state law that evidences the representative's authority is available upon request.
- It is important to understand that you are not expected to be an expert on legal documentation. However, it is expected that you will use good professional judgment when working with a potential beneficiary and a family member or other party who is indicating that they have authority to act on the potential beneficiary's behalf.

SilverScript Auditing and Monitoring

As part of SilverScript's responsibility to monitor and oversee its marketing representatives' activities, periodic audits are conducted. The goals of these audits are:

- To review the marketing materials used in the solicitation and sales of our plan offerings.
- To monitor the marketing oversight activities of contracted national marketing organizations and the conduct of their marketing agents, as well as agents employed by CVS Health.

Audits may include:

- Review of agent licensure, training and certification.
- Review of compensation, system access and reporting.
- Review of material being used for marketing purposes to be sure it is all CMS-approved.

SilverScript is required to conduct outbound education and verification efforts to beneficiaries to ensure that the beneficiary understands the plan rules. For enrollments through a marketing representative, we will ensure that the marketing activity was conducted in accordance within CMS regulations.

CMS Auditing and Monitoring

In addition to SilverScript audits, CMS conducts audits throughout the year using several mechanisms to ensure marketing agent compliance, including:

- Prospective and retrospective review of marketing materials to ensure that they were approved by CMS.
- Marketplace surveillance of agent activities.
- Partnership with states' departments of insurance and beneficiary advocates, such as the National Association of Insurance Commissioners (NAIC).
- Secret shopping by CMS representatives.
- Monitoring marketing activity complaints and issues using the CMS compliant tracking module (CTM).
- Attendance of marketing/sales events.

Disciplinary Action

Current SilverScript policy provides for the immediate termination of an agent's contract to market SilverScript upon evidence of a violation of any law, regulation, or CMS guidance regarding the marketing or distribution of Medicare products.

CMS has the authority to levy a financial penalty for each beneficiary affected, or likely to be affected, by each violation.

Your Disclosure Requirement

It is your obligation to disclose to a potential beneficiary that you are contracted with SilverScript to market the plan offerings and that you may be compensated based on the beneficiary's enrollment.

- In doing so, you must not withhold, dilute or minimize the fact that you are compensated based on enrollment in the plan.
- You are required to disclose this information to the potential beneficiary in writing either prior to, or at the time of their enrollment – not after the beneficiary has enrolled.
- You MUST disclose all relevant aspects of SilverScript's products that you are marketing.
    - However, never disclose more than you know.
    - If you are unsure of an answer to a question, it is important not to provide a response that could be incorrect. In doing so, you could give the potential beneficiary the impression that you are misrepresenting the facts. Instead, tell the beneficiary that you will get back to him or her as soon as possible with answers to the requested information.

Best Practices

- Training on and understanding of CMS Marketing Guidelines, federal laws and statues, regulatory compliance and the consequences of violating these regulations is a CMS requirement.
- It can also go a long way to ensure that you are providing accurate and complete information to a potential beneficiary so that they can make an informed decision on the prescription drug plan that best suits their needs.
- Compliance also recommends the best practice guidelines that are provided in the following slides.

Give a Copy/Make a Copy/Keep a Copy

When you are showing/using documents to/with a potential beneficiary:

- You must give them every document defined in the enrollment kit.
- You must give them a copy of every document that they sign.
- It is in your best interest to make a copy of each document that you have a potential beneficiary sign and keep the copy in a file designated solely for that beneficiary.

In this way, you can help ensure that there should be no confusion as to what information was provided to the beneficiary during your initial and subsequent meetings and presentations.

Dot the “i” and Cross the “t”

- Dealing with potential beneficiaries requires special skills, patience and knowledge. Equally important, it requires you to be very precise with the information that you provide them whether written or verbally.
- Double check everything that you do. While this might be an arduous task, it is one that will help keep you in compliance.
- Ensure that your potential beneficiary understands the product offering. If there is any doubt, review the material again. Be sure to cover any and all items relevant to the transaction.

Your Reporting Obligations

- You are required to report any suspected non-compliance and/or fraud, waste or abuse with any of CMS's and/or SilverScript's rules and regulations as soon as you become aware of it. You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.
- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to any resources available to you as outlined in the next slide.

Compliance Resources

Feel free to contact the SilverScript Medicare Part D Compliance department if you are unsure of the answer to a question, want verification on a process, or need some direction on a compliance topic.

The CVS Health Ethics Line:

(877) CVS-2040 or Ethics.BusinessConduct@cvs.com

Patrick Jeswald, Chief Compliance Officer, SilverScript, Medicare Part D

480-661-2030 or Patrick.Jeswald@caremark.com

William Will, Director, Compliance / Fraud, Waste & Abuse

480-661-2383 or William.Will@CVSHealth.com