Weekly Top Ten Scripts

10/07/2007 – 10/13/2007

Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage

MP MSP Medicare Secondary Payer

Plan Complaints

CS Medicare.gov Tools

CC Medicare Cost and Premiums

CC Part B Covered/Noncovered Services

CS Ordering Replacement Medicare Card

CC Preventive Services Overview

Drug Coverage Cost Information

CC Part A Covered/Noncovered Services

Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage

START » This script outlines each election period to help you determine if the beneficiary is eligible to join, switch, or disenroll. If that is what the beneficiary wants to do, please click on the first button below.

Join, switch, or leave (disenroll / opt out) a drug plan or Medicare Advantage Plan
This will take you through the different election periods to determine if the caller is eligible.

Misleading SEP
This is a shortcut to the information about marketing misrepresentation.

General election period information
This will give you a description of the election periods before going through the script.

Disenrollment status check OR cancellation.
This can be used by Tier I or Tier II CSRs.

Caller wants to disenroll and NGD is down.

Tier II CSRs only - Disenrollment process
Use AFTER the join/switch/leave button OR a warm Tier I transfer.

Tier II CSRs only - Claims/services are being denied after MA disenrollment

Shortcut Links
These shortcut links should be used after the script directs you to.

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Tier I and Tier II **Shortcut** links to be used after the script directs you to:

A	**B**	**C**	**D** Tier II Only
E Tier II Only	**F** Tier II Only	**G** Tier II Only	**H** Tier II Only
I Tier II Only	**J** Tier II Only	**K** Tier II Only	**L** Tier II Only
M Tier II Only	**N**	**O**	

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General election period information

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There are certain times during the year when you can join, switch, or disenroll.

For Medicare Advantage Plans, the election periods are:

1. Initial Coverage Election Period - you can join a Medicare Advantage Plan when you are first eligible for Medicare.
2. Special Enrollment Period - you may make changes to your coverage in certain situations.
3. Annual Election Period - November 15 to December 31 of each year.
4. Open Enrollment Period - January 1 to March 31 of each year.

From January 1, 2007 through July 31, 2007, there was a one-time Limited Open Enrollment Period (L-OEP). If you were in Original Medicare, you could join a Medicare Advantage Plan that did not include drug coverage any time that you were not already in an election period. This did not apply to Medicare Medical Savings Plans (MSAs), MA-PDPs, or PDPs. However, this enrollment period is now over and cannot be used.

For Medicare drug plans, the election periods are:

1. Initial Enrollment Period - you can join a drug plan when you are first eligible for Medicare.
2. Special Enrollment Period - you may make changes to your coverage in certain situations.
3. Annual Election Period - November 15 to December 31 of each year.
4. Open Enrollment Period for Medicare Advantage Plans - January 1 to March 31 of each year.

Generally, you can only make changes during the annual election period, which is from November 15 to December 31 of each year. I can see if you are eligible to enroll, switch, or disenroll in another enrollment period (such as the initial enrollment period or the special enrollment period). **CLICK HERE to begin.**

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Open Enrollment Period

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You may be able to make a change during the open enrollment period for Medicare Advantage Plans. From January 1 - March 31, which is the open enrollment period, the following changes can be made:

If you are already in:	**You may be able to enroll in:**
Medicare Advantage Prescription Drug Plan	- another Medicare Advantage Prescription Drug Plan or - Original Medicare + Prescription Drug Plan or - PFFS that doesn't offer drug coverage + a stand alone Prescription Drug Plan
Medicare Advantage only	- another Medicare Advantage only or - Original Medicare only
Original Medicare + Prescription Drug Plan	- Medicare Advantage Prescription Drug Plan or - PFFS that doesn't offer drug coverage + same stand alone Prescription Drug Plan
Original Medicare only	- Medicare Advantage with no drug coverage
PFFS that doesn't offer drug coverage + a stand alone Prescription Drug Plan	- Medicare Advantage Prescription Drug Plan or - another PFFS that doesn't offer drug coverage + same stand alone Prescription Drug Plan or - Original Medicare + Prescription Drug Plan

Medicare Advantage Plans are **not required** to accept applications during the open enrollment period. You should check with the plan to see if they are accepting new members. However, if you want to disenroll, the plan must accept your disenrollment request so that you can return to Original Medicare.

You will be disenrolled from your Medicare Advantage Plan (MA or MA PDP) if you decide to join another plan (MA, MA PDP or PDP) depending on the type of change you are allowed to make.

If you disenroll during this open enrollment period, your disenrollment will be effective on the last day of the month in which you disenroll. If you switch plans, your new plan will start on the first day of the next month.

Please keep in mind that if you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan.

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Join, switch, or leave (disenroll / opt out)

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Click on the type of plan that the caller **wants to join** or **wants to disenroll from**:

Medicare Advantage Plan (no drug coverage)	**Drug Plan (PDP) or Medicare Advantage Drug Plan (MA PDP)** ("drug plan" throughout the script refers to both)

If you enroll, switch or disenroll but change your mind before the change goes into effect, you must call your plan to cancel the enrollment/disenrollment request. If applicable, you should also contact the plan that you want to stay in. Once your plan becomes effective, you must wait until your next enrollment period (special or annual) to make changes to your coverage. The last plan that you join will be the one that becomes effective. (For example, if you try to join 2 plans in one month, the last plan will be effective.)

Please keep in mind that if you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan.

Medicare Advantage Plans include: (click here for a definition of any of the following plans)

- Coordinated Care Plans (CCPs)
  - Health Maintenance Organizations (HMOs)
    - ~ Cost Plans
  - Provider-Sponsored Organizations (PSOs)
  - Preferred Provider Organizations (PPOs)
    - ~ Local PPO
    - ~ Regional PPO
  - Special Needs Plans (SNP)
- Private Fee-for-Service (PFFS) Plans
- Medical Savings Account (MSA) Plans
- Religious Fraternal Benefit (RFB) Society Plans

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Medicare Advantage Definitions

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- **Medicare Advantage Plan** - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). It is sometimes referred to as "Part C" of the Medicare program.
- **Coordinated Care Plans (CCPs)** - A plan that includes a Medicare-approved network of providers that must deliver a benefit package approved by the Centers for Medicare and Medicaid Services (CMS).
- **Point of Service (POS)** - A benefit option that an MA coordinated care plan can offer to its members. Under the POS benefit option, the MA plan allows members the option of getting certain services outside of the MA plan's provider network for an additional cost.
- **Health Maintenance Organizations (HMOs)** - A coordinated care plan where a group of doctors, hospitals, and other health care providers agree to give health care to

people with Medicare for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

- **Cost Plans** - A plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP).
- **Provider-Sponsored Organizations (PSOs)** - A coordinated care plan that is established or organized, and operated by a provider or group of affiliated providers.
- **Preferred Provider Organizations (PPOs)** - A coordinated care plan that has a network of providers that have agreed to a specified reimbursement for covered benefits and provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers.
- **Local PPO** - A PPO with a service area that is smaller than a Regional PPO; the service area may consist of a county, partial county, or multiple-county service areas.
- **Regional PPO** - A PPO that can only be offered in an MA Region, which is defined as an area within the 50 States and the District of Columbia.
- **Special Needs Plans (SNP)** - Any type of coordinated care plan that meets the Centers for Medicare and Medicaid Services' SNP requirements and either exclusively enrolls special needs individuals or enrolls a greater proportion of special needs individuals.
- **Private Fee-for-Service (PFFS) Plans** - A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.
- **Medical Savings Account (MSA) Plans** - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.
- **Religious Fraternal Benefit (RFB) Society Plans** - A Medicare health plan which may restrict enrollment to members of the church, convention or group with which the society is affiliated.

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Medicare Advantage

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Is this change for 2007 or 2008?

2007 Includes SEP and EE reasons.	2008

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Medicare Advantage Initial Coverage Election Period

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****CSR NOTE:** If the caller wants to **disenroll**, CLICK HERE for SEP reasons.**

If you are newly eligible for both Medicare Part A **and** Part B because of age or disability, you can join a Medicare Advantage Plan during the 7-month period that starts 3 months before the month you are eligible for Medicare Part A and Part B and ends 3 months after you are eligible for Medicare Part A and Part B.

Enrolling in Part B
If you are working and covered by an employer group health plan and you do not enroll in Part B during your Medicare initial enrollment period, you will have an opportunity to enroll in Part B through a special enrollment period when you retire. Since you must have both Part A and Part B in order to join a Medicare Advantage Plan, you will be able to enroll in a Medicare Advantage Plan starting 3 months before your Part B coverage starts (even if you already have Part A).

**Does the beneficiary qualify for the initial coverage election period?

If YES, click here to transfer to Tier II.
If NO, click here for SEP language.

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TIP BOX:

SCRIPT = EE Medicare Initial General and Transfer Enrollment Periods, for information on Part B enrollment periods.
SCRIPT = EE Special Enrollment Period for Working Aged, for information on Part B enrollment periods.

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Medicare Advantage Special Enrollment Period

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READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you. Some of the special enrollment periods that I list may be limited to only an enrollment or disenrollment request (meaning some will not allow one or the other).

The reasons are:
Click for more info about each

1. You **move** and are no longer eligible for your Medicare Advantage Plan because you are outside of the service area.
2. You live in, move into, or move out of an institution, such as a **long term care (LTC) facility**.
3. Your Medicare Advantage Plan is **terminating/non-renewing** its contract.
4. You **join or leave** an **employer/union group health plan**.
5. You **join or leave** a Program of All-inclusive Care for the Elderly (**PACE**).
6. You receive the **extra help** (Medicaid, Medicare Savings Program, SSI, applied for LIS and approved).
7. You **left a Medigap** policy to join a Medicare Advantage Plan for the first time. You now want to join another Medigap policy and **return to Original Medicare** and it has been **less than a year** since you joined the Medicare Advantage Plan.
8. Your eligibility for Medicare was made **retroactively**.
9. You have End-Stage Renal Disease (**ESRD**) and your eligibility for Medicare was made **retroactively**.
10. In the **last 12 months**, you joined a Medicare Advantage Plan during the initial enrollment period surrounding your **65th birthday**. You now want to **return to Original Medicare**.
11. You are either gaining or losing **Medicare Special Needs Plan** status.
12. You are calling because you are no longer in the plan you thought you had been in since 2006 or you are requesting a retroactive change to your 2006 enrollment (**Enrollment Reconciliation**).
13. You were **misled into joining a Medicare Advantage Plan** (with or without drug coverage) when you thought you were joining a different type of plan. You want to disenroll or switch to the plan you originally wanted. **Check the MA PDP tab to verify that the caller is in an MA Plan.**
14. You are affected by the **termination** of the **America's Health Choice**, Inc.'s Medicare Advantage Plan (H1034).

**If above reasons don't apply, CLICK HERE for EE and AEP language.

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Medicare Advantage Special Enrollment Period

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You must notify your current plan that you are moving.

QUALIFICATIONS:
This special enrollment period exists for the following situations:

1. You are no longer eligible for your Medicare Advantage Plan because you permanently moved out of the plan's service area.
2. You will have new Medicare Advantage Plans or Medicare drug plans available to you because you are permanently moving to a different area.

If your current plan offers coverage in your new area, you can choose to keep that plan or you can switch to a different plan.

WHEN TO MAKE A CHANGE:
You can join a Medicare Advantage Plan in your new area as early as the first day of the month before you move. This way, your new coverage can begin the first day of the month in which you move. Or, you can join up to 2 months after you move.

EFFECTIVE DATE OF COVERAGE:
You can choose the effective date to be up to 3 months after the month in which the Medicare Advantage Plan receives your application. However, the effective date cannot be earlier than the date you move.

MORE THAN 6 MONTHS OUT OF CURRENT PLAN'S SERVICE AREA:
If you are out of the service area for more than six months without telling your plan and they find out you are not in the service area, your special enrollment period then starts at the beginning of the sixth month and stops at the end of the eighth month.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS:
You get a continuous open enrollment period if you live in, move into, or move out of a:

- Skilled nursing facility (SNF)
- Nursing facility (NF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Psychiatric hospital or unit
- Rehabilitation hospital or unit
- Long-term care hospital
- Swing-bed hospital

WHEN TO MAKE A CHANGE:
If you or live in or enter one of these facilities, you get an ongoing open enrollment period for the time you're in the facility. The enrollment period ends 2 months after you leave the facility.

Caller wants to enroll	**READ:** Medicare Advantage Plans are **not required** to accept applications during the open enrollment period. You should check with the plan to see if they are accepting new members. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** Medicare Advantage Plans are **not required** to accept applications during the open enrollment period. You should check with the plan to see if they are accepting new members. If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. The plan must accept your disenrollment request so that you can return to Original Medicare. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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If your plan is not renewing its contract or the plan is ending, you get a special enrollment period to join another plan. The plan will let you know what your options are.

WHEN TO MAKE A CHANGE AND EFFECTIVE DATE OF COVERAGE:
The special enrollment period to make a change and the effective date of the new plan will depend on the situation. For example:

- **If the contract is not renewing,** the special enrollment period begins October 1 and ends December 31. You can choose to have an effective date of November 1, December 1, or January 1, as long as the plan receives your request before the first of the month.
- **If the plan is ending,** the special enrollment period begins 2 months before the proposed end date and it ends one month after the month the plan ends. If you don't want to join another Medicare Advantage Plan, you will automatically return to Original Medicare.
- **If Medicare tells the plan to end,** the special enrollment period begins one month before the end date and ends 2 months after the end date. If you don't want to join another Medicare Advantage Plan, you will automatically return to Original Medicare.
- **If Medicare tells the plan to end immediately,** you will receive a notice that explains the special enrollment period.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

TIP BOX:

SCRIPT = EE Medicare Advantage Plan Nonrenewal

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS:
You get a special enrollment period if:

- You want to join or leave an employer-sponsored Medicare Advantage Plan.
- You want to leave your Medicare Advantage Plan to join an employer-sponsored plan of any kind.
- You are leaving your employer-sponsored plan and you want to join a Medicare Advantage Plan.

WHEN TO MAKE A CHANGE:
The special enrollment period is available while you have an employer-sponsored plan and ends 2 months after the employer-sponsored coverage ends.

EFFECTIVE DATE OF COVERAGE:
You can choose the effective date of your enrollment or disenrollment to be up to 3 months from the month in which the plan receives the election request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS AND WHEN TO MAKE A CHANGE:

1. You can leave your Medicare Advantage Plan at any time to join a Program of All-inclusive Care for the Elderly (PACE) program.
2. If you disenroll from a Program of All-inclusive Care for the Elderly (PACE), you have 2 months to join a Medicare Advantage Plan.

EFFECTIVE DATE OF COVERAGE:
The effective date of coverage depends on the situation.

- In most cases, if you choose to **join a plan**, the enrollment effective date will be the first day of the month after the plan receives the request.
- If you choose to **disenroll from a plan**, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS AND WHEN TO MAKE A CHANGE:
If you **qualify for the extra help**, you can join, switch, or disenroll at any time.

If you **lose your extra help status**, you get a special enrollment period to join a different Medicare Advantage Plan. This special enrollment period begins the month you lose extra help eligibility and ends 2 months later.

EFFECTIVE DATE OF COVERAGE:

- If you choose to **join a plan**, the enrollment effective date will be the first day of the month after the plan receives the request.
- If you choose to **disenroll from a plan**, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

CALLER HAS MEDICAID:
If you haven't already, you should talk to your State Medicaid Office to make sure that changing plans won't affect your current coverage.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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CSR NOTE: Check the MA PDP tab to see what type of Medicare Advantage Plan the caller is in and if the effective date is less than a year from today's date.**

**Is the effective date of the MA plan or the MA PDP plan less than one year from today?

YES	NO [Check for other SEPs reasons]

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Medicare Advantage Special Enrollment Period

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Based on the information in our system, you may be eligible for a special enrollment period to leave your Medicare Advantage Plan to return to Original Medicare. The disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

If you want to join a prescription drug plan, you need to wait until the annual election period (November 15 - December 31), unless you qualify for a special enrollment period.

Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS:
Since your Medicare eligibility was made retroactively, you missed your Medicare Advantage initial coverage election period. Because of this, you get a special enrollment period to join a Medicare Advantage Plan. You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

WHEN TO MAKE A CHANGE:
The special enrollment period begins the month you receive notice that you are entitled to Medicare. It ends 2 months after the month you receive the notice.

EFFECTIVE DATE OF COVERAGE:

The effective date of coverage depends on the situation, but it is not earlier than the first day of the month in which you receive notice of your Medicare entitlement

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS:
Since your Medicare eligibility was made retroactively, you missed your Medicare Advantage initial coverage election period. Because of this, you get a special enrollment period if you meet the following conditions:

- You were in a health plan offered by the same Medicare Advantage organization the month before becoming eligible for Medicare Part A and Part B;
- You developed End-Stage Renal Disease (ESRD) while you were a member of that health plan;
- You are still enrolled in that health plan.

WHEN TO MAKE A CHANGE:
The special enrollment period begins the month you receive notice that you are entitled to Medicare. It ends 2 months after the month you receive the notice.

EFFECTIVE DATE OF COVERAGE:
The effective date will be the first day of the month after the Medicare Advantage Plan receives the enrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Special Enrollment Period

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QUALIFICATIONS:
Special Needs Plans are a type of Medicare Advantage Plan. You are eligible for a special enrollment period to join a Medicare Special Needs Plan if you:

- Are in an institution (like a nursing home), or
- Are eligible for both Medicare and Medicaid, or
- Have certain chronic or disabling conditions. The plan will confirm the chronic

condition with your doctor or other provider.

This special enrollment periods end once you join the Special Needs Plan.

If you are no longer eligible for a Special Needs Plan, you are also eligible for a special enrollment period to join another type of plan. This special enrollment period begins the month you lose your special needs status and ends 3 months later.

EFFECTIVE DATE OF COVERAGE

- When joining a **Special Needs Plan,** the effective date will be the first day of the month after the plan receives the enrollment request.
- When joining **another type of plan,** the effective date will vary. You should contact your new plan to find out when it will start.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Medicare Advantage Enrollment Exceptions (EEs)

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ASK: Why did you miss the enrollment period (IEP, AEP, OEP, or SEP)?

DO NOT READ THE FOLLOWING TO THE CALLER

CSR NOTE:

- If the caller enrolled directly with the plan and the plan has no record of the enrollment, OR
- If the caller received a letter stating that they were disenrolled and this is an error (for example: the letter says that they lost Part A and/or Part B OR there is a date of death on file)

These should be regular complaints. **Do not log them as an Enrollment Exception**

(EE). Go to the PDP Plan Referral.

The only reasons that will allow for an exception are:

1. A serious medical emergency, such as an unexpected hospitalization that caused a person to miss enrolling in a Medicare Advantage Plan during an enrollment period (IEP, AEP, OEP, or SEP). **CSR NOTE: The beneficiary has to be in the hospital for the majority of the enrollment period (IEP, AEP, OEP, or SEP). (This is for the Regional Office to decide after the EE is submitted.)**
2. The caller makes a change to their hospice status (joins or leaves) and wants to either join or leave a Medicare Advantage Plan.
3. The caller was misled into joining one type of plan when they thought they were joining another type of plan. (**This does not apply to MA Plans or MA-PDPs because there is a special enrollment period for them.**)
4. The caller is in one of the following plans (check the MA PDP tab, write down the contract ID, and when you return to this script, click **Shortcut O** at the top), they say that the website had a different annual cost for this plan, AND they would not have enrolled based on the true cost. The plans are: H0351, H0544, H0564, H0755, H3366, H3814, H3954, H3964, H4206, H5422, S4802, S5557, S5617, S5660, S5678, S5803, S5904, S5917, S5983.

Examples that would NOT ALLOW for an exception (**if caller falls into one of these categories, DO NOT file an EE**):

- Unsuccessful attempt to call 1-800-MEDICARE or the Medicare Advantage Plan
- Bad weather
- Home computer crashed
- Caller didn't know about Medicare Advantage Plans
- Power or phone failure that prevented enrollment
- A mailed enrollment form returned as undeliverable on or after the end of the enrollment period

Does the caller get an exception based on one of the FOUR reasons above?

YES	NO

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Medicare Advantage Enrollment Exceptions (EEs)

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****CSR NOTE**: Call the Help Queue. You should remain in queue until an actual agent is reached. DO NOT perform a blind transfer. Tell the Help Queue which EE reason you think the caller qualifies for.

- If it is truly an EE, the Help Queue will take ownership of the call and file the EE. Do not process an enrollment or disenrollment. Help Queue will handle the EE request.
- If it is not an EE, the Help Queue will tell you how to handle the call.

****DO NOT FILE AN EE FOR ANY REASON. The Help Queue will be the only ones filing EEs.****

If the caller needs to wait for the AEP, click here for the language.

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Medicare Advantage Annual Election Period

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I'm sorry, but the deadline for enrolling and disenrolling has passed. Your next chance to enroll or disenroll is during the annual election period, which is from November 15 to December 31.

If you want to join another plan, I can help you compare Medicare drug plans now. However, you will need to wait until November 15 to apply. The change in coverage will be effective on January 1 of next year.

****If the caller feels strongly about joining or leaving a plan now, please use your soft**

skills to explain that they have to wait.**

TIP BOX:

SCRIPT = CS Medicare.gov Tools

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Transfer to Tier II

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Tier I CSRs:
Since you are interested in joining a Medicare Advantage Plan, I need to transfer you to a Medicare Benefits Specialist who can help you. You may be asked to repeat some of your personal information. I am going to transfer your call now. Please do not hang up. There may be a period of silence before the Medicare Benefits Specialist answers.
__CSR NOTE__: When transferring for enrollment/disenrollment, tell the Tier II the reason that the beneficiary qualifies for enrollment/disenrollment. For example, let the Tier II know that they qualify for a specific SEP.

If the caller is eligible for an enrollment period (SEP or IEP) that allows them to have a future effective date that is later than the first day of the next month, READ:
Since you want your plan to start later than the first day of next month, you will need to contact the plan that you want to join. You should let them know when you want your coverage to start. **__CSR NOTE__: If the caller is in the IEP, the effective date cannot be earlier than the Medicare effective date.**

Tier II CSRs:
Use script "CS Medicare.gov Tools" and the CSR Plan Finder Tool to assist the caller.

TOP BACK

Disenrollment status check OR cancellation

TOP | BACK

If caller disenrolled and **claims or services are being denied**, transfer to a Tier II.
Tier II: Click here.

If caller wants to **cancel** the disenrollment, click here.

If the caller wants to check the status of a disenrollment, READ:
It normally takes up to 15 business days for a disenrollment request to be processed. Once your request is processed, you will receive a confirmation letter about your disenrollment. You will receive this letter within 30 days from your request. I will check our records to verify your disenrollment request.

CSR NOTE: Check the MA PDP tab to find the disenrollment effective date. When you return to this script, click **Shortcut A** at the top.**

Is there a disenrollment effective date in the MA PDP tab?

YES	NO

TOP BACK

Disenrollment status check

TOP BACK

Your disenrollment was effective on [insert date]. You will be receiving a letter confirming your disenrollment request.

****If it has been more than 30 days and the caller has not received a letter, ASK:**
Did you request the disenrollment through 1-800-MEDICARE or through your plan?

1-800-MEDICARE	Plan

TOP BACK

Disenrollment status check

TOP BACK

****CSR NOTE**: Complete Duplicate Letter Request email template.**

READ: You will receive a confirmation letter within 7 to 10 business days.

TOP BACK

Disenrollment status check

TOP BACK

Please call your plan to request a confirmation letter.

TOP BACK

Disenrollment status check

TOP | BACK

CSR NOTE: Check the Activities applet to view the call history for when the disenrollment was requested. When you return to this script, click **Shortcut B** at the top.**

Is there a disenrollment request in the call history?

YES	NO

TOP | BACK

Disenrollment status check

TOP | BACK

CSR NOTE: Verify date of disenrollment request.

If it has been more than 15 business days (3 weeks) since disenrollment was requested, READ:

Since it has been more than 15 business days since you requested a disenrollment, I will forward your information to the Centers for Medicare and Medicaid Services (CMS) Regional Office to research further. Once your disenrollment request is processed, you will receive a letter confirming it or stating why it was denied.

CSR NOTE: Complete PDP Plan Referral Complaint form. For Complaint Category, select "Enrollment/Disenrollment"; for Complaint, select "Untimely processing of enrollment requests."**

If it has been less than 15 business days (3 weeks) since disenrollment was requested, READ:

I see that you requested disenrollment on [insert date]. Please allow up to 15 business days for your disenrollment request to be processed. Once your request is processed, you will receive a letter confirming your disenrollment request or stating why it was denied. If you do not receive a letter within 30 days from your request, please call us back.

TOP BACK

Disenrollment status check

TOP | BACK

****If the caller is insistent that they received confirmation of the disenrollment**, please verify information in the CSR Plan Finder Tool.**

- If the CSR Plan Finder Tool shows the beneficiary is still enrolled, transfer to a Tier II for investigation.
- If the CSR Plan Finder Tool shows no enrollment, a transfer is not needed. **READ**: Please contact your plan to confirm your disenrollment. If you have a claim that was denied, ask your provider to resubmit the claim.

Disenrollment

TOP BACK

In most cases, the effective date of your disenrollment will be on the last day of the month in which the plan receives your disenrollment request. (**CSR NOTE: Exceptions to the "in most cases" are for enrollment periods that allow you to pick a different date.**)

Once a disenrollment has been processed through our system, we can't cancel it. However, you can contact your plan before the disenrollment effective date to cancel.

Is this request for you or for someone else?

Caller is Beneficiary	Caller is Someone Else

TOP BACK

Disenrollment

Have you already requested a disenrollment before this phone call?

Yes	No

TOP BACK

Disenrollment

TOP | BACK

READ ALL (unless a Tier II received the call as a cold transfer and the caller says that they just did this with another CSR):

If you legally represent the person with Medicare, then you must confirm that you have the authority to make changes for him/her.

You must have a durable Power of Attorney, proof of court-appointed legal guardianship, or proof of other authorization required by State law permitting you to make choices for the person with Medicare (such as a birth certificate for parents of the person with Medicare under the age of 18).

I need you to confirm that you have this authorization and can send proof, if requested, to the plan or to Medicare.

Do you have the necessary authorization and can you produce this document if requested?

Yes	No

DIRECTIONS FOR CSRS:
In the CSR Comments field in the Activities applet, enter the caller's name and phone number and that they attested to being a legal representative.

- If you are a Tier II and this process already happened with a Tier I, enter in the Comments field that attestation was done with another CSR.

TOP BACK

Disenrollment

I'm sorry. At this time I cannot process your disenrollment request. Please call back when you have the proper authorization or when the person with Medicare is present to provide verbal permission.

TOP BACK

Disenrollment

Have you joined another Medicare Advantage Plan (MA) or Medicare Prescription Drug Plan (MA PDP or PDP)?

Yes	No

TOP BACK

Disenrollment

Your enrollment in another Medicare Advantage Plan or Medicare Prescription Drug Plan will automatically disenroll you from your current plan. You will receive a letter from your new plan confirming your enrollment and a letter from your current plan confirming your disenrollment. I can check our records to see if your disenrollment has been processed.

****CSR NOTE**: Check MA PDP tab to see if caller has been disenrolled. If no date is showing, refer caller to his new plan to verify his enrollment.****

TOP BACK

Transfer to Tier II

Tier I CSRs:
I am going to transfer you to a Medicare Benefits Specialist who can help you with your disenrollment request. You may be asked to repeat some of your personal information. I am going to transfer your call now. Please do not hang up. There may be a period of silence before the Medicare Benefits Specialist answers.
****CSR NOTE**: When transferring for enrollment/disenrollment, tell the Tier II why the beneficiary qualifies for enrollment/disenrollment. For example, let the Tier II know that they qualify for a specific SEP.**

Tier II CSRs:
CLICK HERE to start the disenrollment process.

TOP BACK

Transfer to Tier II

Tier I CSRs:
I am going to transfer you to a Medicare Benefits Specialist who can help you with your disenrollment request. You may be asked to repeat some of your personal information. I am going to transfer your call now. Please do not hang up. There may be a period of silence before the Medicare Benefits Specialist answers.
****CSR NOTE**: When transferring for enrollment/disenrollment, tell the Tier II why the beneficiary qualifies for enrollment/disenrollment. For example, let the Tier II know that they qualify for a specific SEP.**

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Opt Out

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By opting out, you will be disenrolled from your current drug plan. You also will not be automatically enrolled by Medicare again.

CSR NOTE: If the beneficiary opts out before the facilitated enrollment effective date, the person will not be enrolled. If the beneficiary opts out of a plan they are currently enrolled in, the disenrollment effective date will be the last day of the month in which the request was made.**

****Read this paragraph only if the effective date is more than 2 months in the future:** Since the effective date of your enrollment is 2 or more months in the future, we cannot process the opt out request yet. Please call us back when you are less than one month from the effective date.

****CSR NOTE**: The opt out request will be good forever. The beneficiary will not need to call and do it again in the future.

Is this request for you or for someone else?

Caller is Beneficiary	Caller is Someone Else

Opt Out

TOP BACK

READ ALL (unless a Tier II received the call as a cold transfer and the caller says that they just did this with another CSR):

If you legally represent the person with Medicare, then you must confirm that you have the authority to make changes for him/her.

You must have a durable Power of Attorney, proof of court-appointed legal guardianship, or proof of other authorization required by State law permitting you to make choices for the person with Medicare (such as a birth certificate for parents of the person with Medicare under the age of 18).

I need you to confirm that you have this authorization and can send proof, if requested, to the plan or to Medicare.

Do you have the necessary authorization and can you produce this document if requested?

Yes	No

DIRECTIONS FOR CSRS:
In the CSR Comments field in the Activities applet, enter the caller's name and phone number and that they attested to being a legal representative.

- If you are a Tier II and this process already happened with a Tier I, enter in the Comments field that attestation was done with another CSR.

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Opt Out

Have you already requested (before this phone call) to opt out of this plan by contacting 1-800-MEDICARE?

Yes	No

TOP BACK

Opt Out

It normally takes up to 15 business days for the opt out request to be processed. Once your request is processed, you will receive a letter confirming your decision to decline Medicare prescription drug coverage. I will check our records to verify your opt out request.

****If it has been longer than 15 business days since the disenrollment request:**

- Tier I: Transfer to Tier II
- Tier II: Verify that the Opt Out Flag is "Y" and click here.

TOP BACK

Opt Out

To get Medicare drug coverage later, all you have to do is call us back.

If you had Medicaid drug coverage and decide not to get Medicare drug coverage now, you will be without the drug coverage formerly provided by Medicaid and your drug coverage will have to come from somewhere else.

Do you want to opt out of the Medicare drug coverage?

Yes	No

TOP BACK

Opt Out

You will stay enrolled in the plan that you are currently in unless you decide to disenroll later.

TOP BACK

Disenrollment or Opt Out

TOP BACK

CSR NOTE: Check the MA PDP tab to make sure that the caller is already in a plan. When you return to this script, click **Shortcut C** at the top.

****CSR NOTE**: We cannot disenroll people from demonstration projects. Most demonstration projects start with the number 90. **The following demonstration projects start with an "H":**

H5443 – Care Level Management (Care Level Management Direct, Inc)
H5445 – Health Buddy Program (Health Hero Network, Inc. Demo)
H2232 – Mass General Care Management (Massachusetts General Physicians)
H3348 – Montefiore Care Guidance (Montefiore Medical Center)
H5444 – RMS KEY to Better Health (RMS DM, LLC Demo Project)
H4532 – Texas Senior Trails (Texas Tech Physicians Associates)
H5413 – LifeMasters Program in Florida (LifeMasters Supported Selfcare, Inc. Demo Project)
H8011 – MPower Health Medicare Medical Savings Account (MSA)

Click here if the caller is in a demonstration project (that starts with 90 or is listed above) and wants to leave.

Caller is in plan - continue	NGD doesn't show a plan

TOP BACK

Disenrollment or Opt Out

TOP BACK

If you do not want to switch plans, you can disenroll. If you disenroll from your Medicare Advantage Plan and you do not join another Medicare Advantage Plan, you will automatically return to Original Medicare.

AUTO-ENROLLED AND OPT OUT:
If you were automatically enrolled by Medicare and you don't want a Medicare drug plan, you must "opt out" of the coverage so that you are not automatically enrolled into another plan.

PENALTY:
If you drop your Medicare drug coverage and don't join another plan until later, you may have to pay a penalty for being without creditable coverage. This means your monthly premium will be increased. If you DO have creditable coverage, you will not have to pay a penalty if you decide to join a Medicare drug plan later. Creditable coverage is drug coverage that is at least as good as Medicare's standard coverage. ****See script** "Drug Coverage Cost Information" for more information.**

****What does the caller want to do?**

Disenroll (MA and PDP)	**Opt Out** (only for auto-enrolled or facilitated enrolled; not for MA Plans without drug coverage)

TOP BACK

Demonstration Disenrollment

If you are in a demonstration project, you are still covered by Original Medicare. If you want to leave the demonstration, you should contact the plan that offers it. ****See script** "CC Medicare Demonstrations and Pilot Programs" for information.**

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Medicare Advantage Plan 2008

TOP BACK

I can help you compare Medicare Advantage Plans now. However, the annual election period begins on November 15. On or after November 15, you will be able to enroll into a Medicare Advantage Plan, with coverage starting on January 1.

TIP BOX:

SCRIPT = CS Medicare.gov Tools

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Drug Coverage

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Is this change for 2007 or 2008?

2007 Includes SEP and EE reasons.	2008

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Drug Coverage Initial Enrollment Period

TOP BACK

If you are newly eligible for Medicare (or turning age 65), you can join a Medicare drug plan during a 7-month period, which starts 3 months before the month you are eligible for Medicare (or turn age 65) and ends 3 months after you are eligible for Medicare (or turn age 65). This is true if you are eligible for Medicare because of age or disability. If you join now because of a disability, you will have another initial enrollment period once you turn age 65.

You only need Medicare Part A **or** Part B in order to join a drug plan. You also have to live in the service area of a Medicare drug plan.

QUALIFICATIONS:

- Your Medicare will become effective in the next 3 months, OR
- Your Medicare became effective in the past 3 months, OR
- You get Medicare retroactively, which gives you an initial enrollment period that starts the month in which you receive the notice of Medicare entitlement and continues for three months after this month, OR
- You were on Medicare because of a disability and you are turning age 65 (in the next 3 months or in the past 3 months).

****Does the caller qualify for the IEP?**
If YES, click on situation above depending on the caller.
If NO, click here for SEP language.

Even if you are working and you delay Part B, your initial enrollment period is still 3 months before your Medicare eligibility, the month of your Medicare eligibility, and the 3 months after your Medicare eligibility. This is because you can join a Medicare drug plan with only Medicare Part A coverage (you do not have to have Part B).

TIP BOX:

TIP = At the beginning of the Medicare drug coverage program, the initial enrollment period for all people with Medicare was November 15, 2005 to May 15, 2006.
TIP = You can go to Beneficiaries applet to find the effective date of either Part A or Part B (whichever is **earlier**).
SCRIPT = EE Medicare Initial General and Transfer Enrollment Periods, for information on Part B enrollment periods.
SCRIPT = EE Special Enrollment Period for Working Aged, for information on Part B enrollment periods.

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Drug Coverage Initial Enrollment Period

TOP BACK

WHEN TO MAKE A CHANGE:
Based on the information you provided, you may be able to join a Medicare drug plan because you are in your initial enrollment period. This period starts 3 months before the month you become eligible for Medicare and ends 3 months after the month in which you become eligible for Medicare. (It is a total of 7 months.)

EFFECTIVE DATE OF COVERAGE:
If you apply before your Medicare starts, the drug plan will start on the same day as your Medicare. If you apply after your Medicare starts, your drug plan will start on the first day of the month after your plan receives the application.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Initial Enrollment Period

TOP BACK

WHEN TO MAKE A CHANGE:
Based on the information you provided, you may be able to join a Medicare drug plan because you missed your initial enrollment period. You may get another initial enrollment period that starts the month in which you received notice of your Medicare entitlement and ends 3 months after this month.

EFFECTIVE DATE OF COVERAGE:
Your drug plan will start on the first day of the month after your plan receives the application. You will not get retroactive drug coverage.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

TOP BACK

Drug Coverage Initial Enrollment Period

TOP BACK

WHEN TO MAKE A CHANGE:
Based on the information you provided, you may be able to join a Medicare drug plan because you are in your initial enrollment period. This period starts 3 months before the month you turn age 65 and ends 3 months after the month in which you turn age 65. (It is a total of 7 months.)

EFFECTIVE DATE OF COVERAGE:
If you apply before the month in which you turn age 65, the drug plan will start on the first day of the month you turn age 65. If you apply after you turn age 65, your drug plan will start on the first day of the month after your plan receives the application.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Enrollment

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I can help you compare plans and apply today.

CSR NOTE: Use script "CS Medicare.gov Tools" and the CSR Plan Finder Tool.**

If the caller is eligible for an enrollment period (SEP or IEP) that allows them to have a future effective date that is later than the first day of the next month, READ:
Since you want your plan to start later than the first day of next month, you will need to contact the plan that you want to join. You should let them know when you want your coverage to start. **CSR NOTE**: If the caller is in the IEP, the effective date cannot be earlier than the Medicare effective date.**

CHANGED MIND:
If you change your mind, you can switch plans or cancel your enrollment **before** the effective date of your plan. Once your plan becomes effective, you have to wait until the next enrollment period (including a special enrollment period) to make changes to your coverage.

PENALTY:
You may have to pay a penalty if you didn't join a drug plan when you were first eligible, even if you are given a special enrollment period. ****See script** "Drug Coverage Cost Information" for information on the late enrollment penalty.**

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Drug Coverage Special Enrollment Period

TOP BACK

If you don't qualify for a special enrollment period, your next chance to join, switch or disenroll will be during the annual election period, which is November 15 to December 31. Any change made during the annual election period will take effect on January 1 of next year.

Generally, once you join, switch, or disenroll, the special enrollment period is over. Your enrollment or disenrollment request is not guaranteed until you get a letter from the plan. The plan will check your eligibility for a special enrollment period. Some of the special enrollment periods that I list may be limited to only an enrollment or disenrollment request (meaning some will not allow one or the other).

****CSR NOTE:** For the full list of reasons, CLICK HERE. Otherwise, follow the links/ questions below.**

1. Do you qualify for the extra help? **Check the MA PDP tab** >YES
2. Do you (or did you previously) have drug coverage through another type of insurance? >YES
3. Are your living arrangements changing? >YES
4. >Other

TOP BACK

Drug Coverage Special Enrollment Period

TOP BACK

READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you.

The reasons are:
Click for more info about each

1. You receive the **extra help** (Medicaid, Medicare Savings Program, SSI, applied for LIS and approved).
2. You **lost** your eligibility for the **extra help**, and you want to switch plans or disenroll.
3. You **join or leave** a Program of All-inclusive Care for the Elderly (**PACE**).
4. You are enrolled in a State Pharmacy Assistance Program (**SPAP**). If caller doesn't know if they are in an SPAP, click here.

****If above reasons don't apply, CLICK HERE (for EE and AEP language).**

Drug Coverage Special Enrollment Period

TOP BACK

READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you.

The reasons are:
Click for more info about each

1. You **involuntarily** lose your current **creditable** drug coverage.
2. You **join or leave a creditable** employer/union group-sponsored health plan (including COBRA).
3. You joined a Medicare drug plan, but later found out that **you have other drug coverage** that is **creditable**. Because of this, you want to **disenroll** from the Medicare drug plan.
4. You **thought you had other drug coverage that was creditable**, but later found out that it is **not** creditable. You now want to **join** a drug plan.
5. You **join or leave** a Program of All-inclusive Care for the Elderly (**PACE**).
6. You are enrolled in a State Pharmacy Assistance Program (**SPAP**). If caller doesn't know if they are in an SPAP, click here.
7. You **left a Medigap policy** to join a Medicare Advantage Plan for the first time. You now want to join another Medigap policy and **return to Original Medicare** and it has been **less than a year** since you joined the Medicare Advantage Plan.
8. In the **last 12 months**, you joined a Medicare Advantage Plan during the initial enrollment period surrounding your **65th birthday**. You now want to **return to Original Medicare**.
9. You have TRICARE, VA benefits or other creditable drug coverage and you enrolled in a Medicare drug plan, **causing this other coverage to become secondary**. You want to disenroll from the Medicare drug plan. OR You have a Medicare drug plan and you want to disenroll in order to join TRICARE or the VA.

****If above reasons don't apply, CLICK HERE (for EE and AEP language).**

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Drug Coverage Special Enrollment Period

TOP BACK

READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you.

The reasons are:
Click for more info about each

1. You **move**, or are moving, outside the service area of the plan (this includes someone who is leaving prison and someone who recently moved back into the United States).
2. You live in, move into, or move out of an **institution**, such as a long term care (LTC) facility.

****If above reasons don't apply, CLICK HERE (for EE and AEP language).**

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Drug Coverage Special Enrollment Period

TOP | BACK

READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you.

The reasons are:
Click for more info about each

1. You don't have Part A and you **enroll in Part B** during the **general enrollment period** (January - March). **Check Beneficiaries applet - there should not be an effective date for Part A AND the effective date for Part B should be July 1. If both are true, click here. **
2. You are either gaining or losing **Medicare Special Needs Plan** status. Therefore, you either want to join or leave a Medicare drug plan.
3. Your Medicare drug plan is **terminating/non-renewing** its contract.
4. You are calling because you are no longer in the plan you thought you had been in since 2006 or you are requesting a retroactive change to your 2006 enrollment (**Enrollment Reconciliation**).
5. You were **misled into joining a Medicare Advantage Plan** (with or without drug coverage) when you thought you were joining a different type of plan. You want to disenroll or switch to the plan you originally wanted. **Check the MA PDP tab to verify that the caller is in an MA Plan.**
6. You are affected by the **termination** of the **America's Health Choice**, Inc.'s Medicare

Advantage Plan (H1034) or Medicare prescription drug plan (S9086).

****If above reasons don't apply, CLICK HERE (for EE and AEP language).**

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Drug Coverage Special Enrollment Period

TOP | BACK

READ: I am about to read a list of reasons that would allow a special enrollment period. Please stop me if you hear a reason that applies to you.

The reasons are:
Click for more info about each

1. You receive the **extra help** (Medicaid, Medicare Savings Program, SSI, applied for LIS and approved).
2. You **lost** your eligibility for the **extra help**, and you want to switch plans or disenroll.
3. You **move**, or are moving, outside the service area of the plan (this includes someone who is leaving prison and someone who recently moved back into the United States).
4. You live in, move into, or move out of an **institution**, such as a long term care (LTC) facility.
5. You don't have Part A and you **enroll in Part B** during the **general enrollment period** (January - March). **Check Beneficiaries applet - there should not be an effective date for Part A AND the effective date for Part B should be July 1. If both are true, click here. **
6. You **involuntarily** lose your current **creditable** drug coverage.
7. You **join or leave a creditable** employer/union group-sponsored health plan (including COBRA).
8. You joined a Medicare drug plan, but later found out that **you have other drug coverage** that is **creditable**. Because of this, you want to **disenroll** from the Medicare drug plan.
9. You **thought you had other drug coverage that was creditable**, but later found out that it is **not** creditable. You now want to **join** a drug plan.
10. You **join or leave** a Program of All-inclusive Care for the Elderly (**PACE**).
11. You are enrolled in a State Pharmacy Assistance Program (**SPAP**). If caller doesn't know if they are in an SPAP, click here.
12. You **left a Medigap policy** to join a Medicare Advantage Plan for the first time. You now want to join another Medigap policy and **return to Original Medicare** and it has been **less than a year** since you joined the Medicare Advantage Plan.

13. In the **last 12 months**, you joined a Medicare Advantage Plan during the initial enrollment period surrounding your **65th birthday**. You now want to **return to Original Medicare**.
14. You are either gaining or losing **Medicare Special Needs Plan** status. Therefore, you either want to join or leave a Medicare drug plan.
15. You have TRICARE, VA benefits or other creditable drug coverage and you enrolled in a Medicare drug plan, **causing this other coverage to become secondary**. You want to disenroll from the Medicare drug plan. OR You have a Medicare drug plan and you want to disenroll in order to join TRICARE or the VA.
16. Your Medicare drug plan is **terminating/non-renewing** its contract.
17. You are calling because you are no longer in the plan you thought you had been in since 2006 or you are requesting a retroactive change to your 2006 enrollment (**Enrollment Reconciliation**).
18. You were **misled into joining a Medicare Advantage Plan** (with or without drug coverage) when you thought you were joining a different type of plan. You want to disenroll or switch to the plan you originally wanted. **Check the MA PDP tab to verify that the caller is in an MA Plan.**
19. You are affected by the **termination** of the **America's Health Choice**, Inc.'s Medicare Advantage Plan (H1034) or Medicare prescription drug plan (S9086).

****If above reasons don't apply, CLICK HERE (for EE and AEP language).**

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Drug Coverage Special Enrollment Period

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QUALIFICATIONS AND WHEN TO MAKE A CHANGE:
If you **qualify for the extra help,** you can join, switch, or disenroll at any time.

EFFECTIVE DATE OF COVERAGE:

- If you choose to **join a plan,** the enrollment effective date will be the first day of the month after the plan receives the request.
- If you choose to **disenroll from a plan,** the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

CALLER HAS MEDICAID:
If you haven't already, you should talk to your State Medicaid Office to make sure that changing plans won't affect your current coverage.

****CSR NOTE:** If the caller **lost his or her extra help status**, CLICK HERE for information on that SEP.**

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

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LOSE EXTRA HELP FOR NEXT YEAR:
If you lose your extra help status because you are no longer eligible for the following calendar year, you get a special enrollment period to join a different drug plan or to disenroll from your current drug plan. This special enrollment period is from January 1 to March 31 of each year.

LOSE EXTRA HELP DURING THIS YEAR:
If you lose your extra help status at another time during the year, you get a special enrollment period to join a different drug plan or to disenroll from your current drug plan. This special enrollment period begins the month in which you lose the extra help eligibility and ends 2 months later.

EFFECTIVE DATE OF COVERAGE:
If you choose to join a plan, the enrollment effective date will be the first day of the month after the plan receives the request. If you choose to disenroll from a plan, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

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QUALIFICATIONS:
This special enrollment period exists for the following situations:

1. You are no longer eligible for your drug plan because you permanently moved out of the plan's service area.
2. You were not eligible to join a Medicare drug plan because you didn't live in a plan's service area, but now you are moving to an area that has drug coverage. This includes people who have been out of the United States and have now moved back to the United States **and** individuals who were incarcerated (in prison) and have now been released.
3. You will have new Medicare drug plans (PDP or MA PDP) available to you because you are permanently moving to a different area. You can join a drug plan in your new area even if you were not in a plan in your old area.

WHEN TO MAKE A CHANGE:
You must notify your current plan that you are moving. You can join a Medicare drug plan in your new area as early as the first day of the month before you move (coverage starts on the first day of the month after the month you request enrollment). This way, your new coverage will begin the first day of the month in which you move. Or, you can join up to 2 months after you move.

EFFECTIVE DATE OF COVERAGE:
If you choose to join a plan, the enrollment effective date will be the first day of the month after the new plan receives the request. If you choose to disenroll from a plan, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

TOP BACK

Drug Coverage Special Enrollment Period

TOP BACK

QUALIFICATIONS:
You get a special enrollment period if you live in, move into, or move out of a:

- Skilled nursing facility (SNF)
- Nursing facility (NF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Psychiatric hospital or unit
- Rehabilitation hospital or unit
- Long-term care hospital
- Swing-bed hospital

WHEN TO MAKE A CHANGE:
If you live in or enter one of these facilities, you get an ongoing special enrollment period for the time you're living in the facility. Once you leave, you will get another special enrollment period to switch plans that lasts up to 2 months after you leave the facility.

EFFECTIVE DATE OF COVERAGE:
If you choose to join a plan, the enrollment effective date will be the first day of the month after the plan receives your request, but not prior to the month your residency begins. If you choose to disenroll from a plan, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

TOP BACK

Since you enrolled in Part B during the general enrollment period (January to March), you can join a drug plan from April 1 to June 30. It will start on July 1.

If it is between April 1 and June 30:

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

TOP BACK

Drug Coverage Special Enrollment Period

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WHEN TO MAKE A CHANGE:
The special enrollment period begins the month you're told of the loss of creditable coverage and either ends 2 months after the loss or 2 months after you're told, whichever is later. If the coverage is lost because you didn't pay your premiums, you won't get a special enrollment period.

EFFECTIVE DATE OF COVERAGE:
The effective date of your enrollment into a drug plan can be the first day of the next month, or you can choose an effective date in the future, but the date cannot be more than 2

months from the end of the special enrollment period.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

TOP BACK

QUALIFICATIONS:
This special enrollment period exists for the following situations:

1. You want to join an employer/union group-sponsored Medicare drug plan.
2. You want to leave a Medicare drug plan because you want to join an employer/union-sponsored plan of any kind.
3. You want to join a Medicare drug plan because you are dropping your employer/union group-sponsored plan (including COBRA).

If you drop your employer/union group-sponsored coverage, you **may not** be able to get it back. You may not be able to drop your employer/union **drug** coverage without also dropping your employer/union **health** coverage.

WHEN TO MAKE A CHANGE:
The special enrollment period lasts for as long as you have an employer/union group-sponsored plan and ends 2 months after the month the employer/union group-sponsored coverage ends.

EFFECTIVE DATE OF COVERAGE:
The effective date of your enrollment into a drug plan can be the first day of the next month, or you can choose an effective date of up to 3 months in the future.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

TOP BACK

Since your other drug coverage is considered to be creditable, you get a special enrollment period to disenroll from your Medicare drug plan. The length and effective date for this special enrollment period depend on the situation.

Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

TOP BACK

Since your other drug coverage is not considered to be creditable, you get a special enrollment period to join a Medicare drug plan. The length and effective date for this special enrollment period depend on the situation.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

Drug Coverage Special Enrollment Period

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QUALIFICATIONS AND WHEN TO MAKE A CHANGE:

1. You can leave your Medicare drug plan at any time to join a Program of All-inclusive Care for the Elderly (PACE) program. Your PACE program will offer prescription drug coverage.

2. If you disenroll from a Program of All-inclusive Care for the Elderly (PACE), you have 2 months to join a Medicare drug plan.

EFFECTIVE DATE OF COVERAGE:
The effective date for this special enrollment period depends on the situation.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

What is the name of the program that you are in?

****CSR NOTE**: Go to "State Pharmacy Assistance Programs (SPAP) and Part D" in Reference Materials to see if that program is on the list of SPAPs.****

If it is on the list, click here.

If it is not, click here to go back to the list of SEPs.

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Drug Coverage Special Enrollment Period

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Read only if the caller is enrolled in a qualified SPAP

WHEN TO MAKE A CHANGE:
You get one chance per calendar year to join, switch, or disenroll drug plans if you are in a qualified State Pharmacy Assistance Program (SPAP).

EFFECTIVE DATE OF COVERAGE:
If you choose to join a plan, the enrollment effective date will be the first day of the month after the plan receives the request. If you choose to disenroll from a plan, the disenrollment effective date will be on the last day of the month in which the plan receives your disenrollment request.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

TIP BOX:

REFERENCE MATERIAL = Access "State Pharmacy Assistance Programs (SPAP) and Part D" in Reference Materials to verify that an organization is a SPAP. The document also contains which SPAPs enrolled their beneficiaries and when this occurred.

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Drug Coverage Special Enrollment Period

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****CSR NOTE**: Check the MA PDP tab to see what type of Medicare Advantage Plan the caller is in and if the effective date is less than a year from today's date.**

Is the effective date of the MA plan or the MA PDP plan less than one year from today?

YES	NO [Check for other SEPs reasons]

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Drug Coverage Special Enrollment Period

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Based on the information you provided, you may be eligible for a special enrollment period to leave your Medicare Advantage Plan to return to Original Medicare and join a prescription drug plan. The length and effective date for this special enrollment period depend on the situation.

****CSR NOTE**: When the caller joins a prescription drug plan, it will automatically disenroll them from the Medicare Advantage Plan and return them to Original Medicare.****

Caller wants to switch to Original Medicare and a prescription drug plan	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

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QUALIFICATIONS:
Special Needs Plans are a type of Medicare Advantage Plan. You are eligible for a special enrollment period to join a Medicare Special Needs Plan if you:

- Are in an institution (like a nursing home), or
- Are eligible for both Medicare and Medicaid, or
- Have certain chronic or disabling conditions. The plan will confirm the chronic condition with your doctor or other provider.

This special enrollment period ends once you join the Special Needs Plan.

WHEN TO MAKE A CHANGE AND EFFECTIVE DATE OF COVERAGE:

- **If you become eligible for a Special Needs Plan,** you can disenroll from your Medicare drug plan at any time in order to join a Special Needs Plan. You will receive your prescription drug coverage from your Special Needs Plan.
- **If you are no longer eligible for a Special Needs Plan,** you may be eligible for a special enrollment period to join a prescription drug plan. The special enrollment period begins on the effective date of your involuntary disenrollment and ends 3 months later. The effective date of your Medicare drug plan will vary. You should contact your plan to find out when it will start.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

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Drug Coverage Special Enrollment Period

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QUALIFICATIONS:
Since you have TRICARE, VA or other creditable drug coverage and a Medicare drug plan, this other coverage is secondary to Medicare. You are eligible for a special enrollment period to disenroll from the Medicare drug plan. This will allow the other coverage to be primary again.

If you have a Medicare drug plan and you have or want to join TRICARE or VA coverage, you are eligible for a special enrollment period to disenroll from your Medicare drug plan. In the case of TRICARE, this will allow the TRICARE coverage to be primary again.

Caller wants to disenroll or opt out	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your disenrollment. Your plan may contact you for more information. CLICK HERE

****If caller believes they are losing TRICARE because they were enrolled in a Medicare drug plan, READ:**
You have not lost or cancelled TRICARE by enrolling in a Medicare drug plan. However, since you have both TRICARE and a Medicare drug plan, the Medicare drug plan will pay first and TRICARE becomes the secondary payer. If your pharmacist checks your insurance status in their system, the pharmacist should see that the Medicare drug plan is primary and TRICARE is the secondary payer for the drug claims. If you disenroll from the Medicare drug plan, TRICARE prescription drug coverage will be primary again. ****CSR NOTE**: If caller wants to disenroll or opt out so that TRICARE is primary, CLICK HERE.**

****If the caller passes disclosure and the MA PDP tab shows they were in a Medicare drug plan but disenrolled previously, READ:**
Our records show that you disenrolled from your Medicare drug plan effective [DATE]. 1-800-MEDICARE cannot send out letters stating that someone does not have a Medicare drug plan. You should contact Express Scripts, TRICARE's pharmacy contractor, and let them know that you are no longer in a Medicare drug plan. You can call TRICARE's Express

Scripts customer call center at 1-866-363-8779.

TIP BOX:

SCRIPT = Drug Coverage and Other Coverage, for general information about TRICARE and VA benefits

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Drug Coverage Special Enrollment Period

TOP BACK

If your plan is not renewing its contract or the plan is ending, you get a special enrollment period to join another plan. The plan will let you know what your options are.

WHEN TO MAKE A CHANGE AND EFFECTIVE DATE OF COVERAGE:
The special enrollment period to make a change and the effective date of the new plan will depend on the situation. For example:

- **If the contract is not renewing,** the special enrollment period begins October 1 and ends December 31. You can choose to have an effective date of November 1, December 1, or January 1, as long as the plan receives your request before the first of the month.
- **If the plan is ending,** the special enrollment period begins 2 months before the proposed end date and it ends one month after the month in which the plan ends. If you don't want to join another Medicare drug plan, you will automatically be disenrolled when your plan ends.
- **If Medicare tells the plan to end,** the special enrollment period begins one month before the end date and ends 2 months after the end date. If you don't want to join another Medicare drug plan, you will automatically be disenrolled when your plan ends.
- **If Medicare tells the plan to end immediately,** you will receive a notice that explains the special enrollment period.

Caller wants to enroll	**READ:** Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE
Caller wants to switch plans	**READ:** If you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information. CLICK HERE

TIP BOX:

SCRIPT = EE Medicare Advantage Plan Nonrenewal

Drug Coverage Enrollment Exceptions (EEs)

TOP BACK

ASK: Why did you miss the enrollment period (IEP, AEP, or SEP)?

DO NOT READ THE FOLLOWING TO THE CALLER

CSR NOTE:

- If the caller enrolled directly with the drug plan and the plan has no record of the enrollment, OR
- If the caller received a letter stating that they were disenrolled and this is an error (for example: the letter says that they lost Part A and/or Part B OR there is a date of death on file)
  These should be regular complaints. **Do not log them as an Enrollment Exception (EE)**. Go to the PDP Plan Referral.

The only reasons that will allow for an exception are:

1. A serious medical emergency, such as an unexpected hospitalization that caused a person to miss enrolling in a drug plan during an enrollment period (IEP, AEP, or SEP). **CSR NOTE: The beneficiary has to be in the hospital for the majority of the enrollment period (IEP, AEP, or SEP). (This is for the Regional Office to decide after the EE is submitted.)**
2. The caller makes a change to their hospice status (joins or leaves) and wants to either join or leave a Medicare drug plan.
3. The caller was misled into joining one type of plan when they thought they were joining another type of plan. (**This does not apply to MA Plans or MA-PDPs because there is a special enrollment period for them.**)
4. The caller lives in Craig, Alaska on Prince Royal Island and is currently enrolled in United/AARP.
5. The caller is in one of the following plans (check the MA PDP tab, write down the contract ID, and when you return to this script, click **Shortcut N** at the top), they say that the website had a different annual cost for this plan, AND they would not have enrolled based on the true cost. The plans are: H0351, H0544, H0564, H0755, H3366, H3814, H3954, H3964, H4206, H5422, S4802, S5557, S5617, S5660, S5678, S5803, S5904, S5917, S5983.

Examples that would NOT ALLOW for an exception (**if caller falls into one of these categories, DO NOT file an EE**):

- Unsuccessful attempt to call 1-800-MEDICARE or the drug plan
- Bad weather
- Home computer crashed
- Caller didn't know about the Medicare drug coverage
- Power or phone failure that prevented enrollment
- A mailed enrollment form returned as undeliverable on or after the end of the enrollment period
- Caller just started taking prescriptions and wants to join a drug plan.
- Caller just changed prescriptions and wants to join or switch plans.

Does the caller get an exception based on one of the FIVE reasons above?

YES	NO

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Drug Coverage Enrollment Exceptions (EEs)

TOP BACK

CSR NOTE: Call the Help Queue. You should remain in queue until an actual agent is reached. DO NOT perform a blind transfer. Tell the Help Queue which EE reason you think the caller qualifies for.

- If it is truly an EE, the Help Queue will take ownership of the call and file the EE. Do

not process an enrollment or disenrollment. Help Queue will handle the EE request.
- If it is not an EE, the Help Queue will tell you how to handle the call.

****DO NOT FILE AN EE FOR ANY REASON. The Help Queue will be the only ones filing EEs.****

If the caller needs to wait for the AEP, click here for the language.

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Drug Coverage Annual Election Period

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I'm sorry, but the deadline for enrolling and disenrolling has passed. Your next chance to enroll or disenroll is during the annual election period, which is from November 15 to December 31.

If you want to join another plan, I can help you compare Medicare drug plans now. However, you will need to wait until November 15 to apply. The change in coverage will be effective on January 1 of next year.

****If the caller feels strongly about joining or leaving a plan now, please use your soft skills to explain that they have to wait.****

TIP BOX:

SCRIPT = CS Medicare.gov Tools

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Drug Coverage 2008

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I can help you compare Medicare drug plans now. However, the annual election period begins on November 15. On or after November 15, you will be able to enroll into a Medicare drug plan, with coverage starting on January 1.

TIP BOX:

SCRIPT = CS Medicare.gov Tools

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This section is only for Tier IIs.

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If the caller is not the beneficiary and hasn't already attested, click here for disenrollment and click here for opt out.

**What does the caller want to do?

Disenroll (MA and PDP)	Opt Out (only for auto-enrolled or facilitated enrolled)

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This section is only for Tier IIs.

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**What type of plan does the caller want to disenroll from?

Medicare Advantage	Medicare Advantage Prescription Drug Plan	Prescription Drug Plan

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****This section is only for Tier IIs.****

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I am going to submit a disenrollment request for you from [insert plan name]. Keep using your current plan until your disenrollment date. After your disenrollment date, [insert plan name] will not cover your health care costs. You will automatically return to Original Medicare.

Once I submit your disenrollment request, I cannot stop or cancel it. However, you can cancel the disenrollment if you call your plan before the disenrollment effective date. A cancellation cannot be processed **after** the disenrollment effective date.

**If the caller wants to re-enroll because they can't cancel their disenrollment, CLICK HERE.

One moment please, while I submit your disenrollment request.

****CSR NOTE**: Go to the MA PDP tab to complete the disenrollment. (When you return to this script, click **Shortcut E** at the top or click here.)**

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****This section is only for Tier IIs.****

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I am going to submit a disenrollment request for you from [insert plan name]. Keep using your current plan until your disenrollment date. After your disenrollment date, [insert plan name] will not cover your prescription drugs or health care costs.

Once I submit your disenrollment request, I cannot stop or cancel it. However, you can cancel the disenrollment if you call your plan before the disenrollment effective date. A cancellation cannot be processed **after** the disenrollment effective date.

**If the caller wants to re-enroll because they can't cancel their disenrollment, CLICK HERE.

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One moment please, while I submit your disenrollment request.

CSR NOTE: Go to the MA PDP tab to complete the disenrollment. (When you return to this script, click **Shortcut E** at the top or click here.)**

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****This section is only for Tier IIs.****

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I am going to submit a disenrollment request for you from [insert plan name]. Keep using your current plan until your disenrollment date. After your disenrollment date, [insert plan name] will not cover your prescription drugs.

Once I submit your disenrollment request, I cannot stop or cancel it. However, you can cancel the disenrollment if you call your plan before the disenrollment effective date. A cancellation cannot be processed **after** the disenrollment effective date.

**If the caller wants to re-enroll because they can't cancel their disenrollment, CLICK HERE.

One moment please, while I submit your disenrollment request.

****CSR NOTE**: Go to the MA PDP tab to complete the disenrollment. (When you return to this script, click **Shortcut E** at the top or click here.)**

TOP BACK

This section is only for Tier IIs.

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I am going to submit an opt-out request for you. This will cancel your enrollment in [plan name]. You will not be enrolled automatically by Medicare again.

If you decide in the future that you want a Medicare drug plan, you can enroll in a new plan during a valid enrollment period.

**If the caller wants to re-enroll because they can't cancel their opt out, CLICK HERE.

One moment please, while I submit your opt-out request.

****CSR NOTE**: Go to the MA PDP tab to complete the disenrollment. (When you return to this script, click **Shortcut E** at the top or click here.)**

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This section is only for Tier IIs.

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**Were you able to complete the disenrollment or opt out request?

YES NO

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This section is only for Tier IIs.

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Closing for disenrollment

I have submitted your request for disenrollment. It normally takes 15 business days to be processed. Your effective date for this disenrollment will be the last day of the month in which the plan receives the request. Once your disenrollment has been processed, you will receive a confirmation letter. It is up to the plan to verify your information and work with Medicare to confirm your disenrollment.

Closing for opt out

I have submitted your request to opt out of Medicare drug coverage and future automatic enrollment into a Medicare drug plan. The effective date will be the last day of the month in which the plan receives the request. It normally takes 15 business days for the opt-out request to be processed. Once your request is processed, you will receive a letter confirming your decision to decline Medicare drug coverage. It is up to the plan to verify your information and work with Medicare to confirm your disenrollment. If you decide you want Medicare drug coverage in the future, you can enroll in a new plan at any time.

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Unsuccessful Disenrollment

TOP BACK

Disenrollment request unsuccessful
I am sorry. I am unable to complete your disenrollment request today. I cannot verify the plan information you provided. If you know the phone number of your plan, you can call them and they will process your disenrollment.

Opt out request unsuccessful
I am sorry. I am unable to complete your opt out request today. I cannot verify the plan information you provided. Please contact the plan to see if you are currently enrolled.

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NGD is Down

TOP BACK

I'm sorry but we are not able to access your records at this time to process your disenrollment request. You can call us back later or you can call your plan to disenroll.

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****This section is only for Tier IIs.****

TOP BACK

CSR Reminder: While verifying disenrollment dates, check the Activities applet to see if the disenrollment has been processed.

Has it been more than 15 business days since you requested a disenrollment?

YES	NO

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****This section is only for Tier IIs.****

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Please allow 15 business days for your disenrollment request to be processed. Once your request is processed, you will receive a confirmation letter.

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This section is only for Tier IIs.

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Did you contact your plan or 1-800-MEDICARE to request the disenrollment?

Plan	1-800-MEDICARE

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This section is only for Tier IIs.

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Are you being denied emergency care because your provider shows that you are still enrolled in a Medicare Advantage Plan?

YES	NO

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This section is only for Tier IIs.

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In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut F at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action

Disenrollment date is the same			Click here
Disenrollment dates are not consistent			Click here
Disenrollment date shown	No disenrollment date shown	No disenrollment date shown	Click here
Disenrollment date is the same		No disenrollment date shown	Click here
Disenrollment date shown	No disenrollment date shown	Disenrollment date shown	Click here
No disenrollment date shown	No disenrollment date shown	No disenrollment date shown	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

TOP BACK

This section is only for Tier IIs.

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Our system is showing that your disenrollment was effective on [insert date]. Please ask your provider to resubmit the claim.

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****This section is only for Tier IIs.****

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Please contact your plan for the status of your disenrollment.

TOP BACK

This section is only for Tier IIs.

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Our system is not showing a disenrollment date for you. Please call your plan regarding your disenrollment request. Once your disenrollment information has been updated in our system, your provider should resubmit your claim to Medicare for processing.

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This section is only for Tier IIs.

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Medicare is aware that there may be problems processing some disenrollments and is working to correct them. I will forward your information to the Centers for Medicare and Medicaid Services (CMS). Once your disenrollment information has been updated in our system, which takes about 15 business days, your provider should resubmit the claim to Medicare for processing. I apologize for any inconvenience this may have caused you.

CSR NOTE: Complete the MA Disenrollment Log. Send an email to your site point of contact (POC) and be sure to include all the specific details about the situation, including what makes it urgent. The subject line should contain the word "urgent."**

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This section is only for Tier IIs.

TOP BACK

Our system is showing that your disenrollment was effective on [insert date]. Please ask your provider to resubmit the claim.

****CSR NOTE**: If it has been more than 5 days from today's date, complete the MA Disenrollment Log.**

TOP BACK

This section is only for Tier IIs.

TOP BACK

Medicare is aware that there may be problems processing some disenrollments and is working to correct them. I will forward your information to the Centers for Medicare and Medicaid Services (CMS). Once your disenrollment information has been updated in our system, which takes about 15 business days, your provider should resubmit the claim to Medicare for processing. I apologize for any inconvenience this may have caused you.

****CSR NOTE**: Complete the MA Disenrollment Log. Send an email to your site point of contact (POC) and be sure to include all the specific details about the situation, including what makes it urgent. The subject line should contain the word "urgent".**

TOP BACK

****This section is only for Tier IIs.****

TOP BACK

Medicare is aware that there may be problems processing some disenrollments and is working to correct them. I will forward your information to the Centers for Medicare and Medicaid Services (CMS). Once your disenrollment information has been updated in our system, which takes about 15 business days, your provider should resubmit the claim to Medicare for processing. I apologize for any inconvenience this may have caused you.

****CSR NOTE**: Complete the MA Disenrollment Log.**

TOP BACK

****This section is only for Tier IIs.****

TOP | BACK

If the Audit Indicator in the MA PDP tab shows that the case was audited, READ:
The disenrollment has been processed. Please ask your provider to resubmit the claim.

If the case has NOT been audited, READ:
Medicare is aware that there may be problems processing some disenrollments and is working to correct them. I will forward your information to the Centers for Medicare and Medicaid Services (CMS). Once your disenrollment information has been updated in our system, which takes about 15 business days, your provider should resubmit the claim to Medicare for processing. I apologize for any inconvenience this may have caused you.

CSR NOTE: Complete the MA Disenrollment Log.**

TOP BACK

This section is only for Tier IIs.

TOP BACK

If the Audit Indicator in the MA PDP tab shows that the case was audited, READ:
The disenrollment has been processed. Please ask your provider to resubmit the claim.

If the case has NOT been audited:
****CSR NOTE**: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD." In the Issue/Complaint field, note that the beneficiary has a letter from the plan with a date different from that on our records.**

TOP BACK

This section is only for Tier IIs.

TOP BACK

Did you receive a letter confirming your disenrollment?

YES	NO

TOP BACK

This section is only for Tier IIs.

TOP BACK

What is the date on your letter? Is the date on the letter correct?

YES	NO

TOP BACK

This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut G at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment dates match date on letter			Click here
Disenrollment dates do not match date on letter			Click here
Disenrollment date matches letter	No disenrollment date or date doesn't match letter	No disenrollment date or date doesn't match letter	Click here
Disenrollment date matches letter		No disenrollment date or date doesn't match letter	Click here
No disenrollment date	No disenrollment date	No disenrollment date	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

TOP BACK

****This section is only for Tier IIs.****

TOP BACK

Please ask your provider to resubmit the claim.

TOP BACK

This section is only for Tier IIs.

TOP BACK

CSR NOTE: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD." In the Issue/Complaint field, note that the beneficiary has a letter from the plan with a date different from that on our records.

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This section is only for Tier IIs.

TOP BACK

CSR NOTE: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD." In the Issue/Complaint field, note that the caller says a confirmation letter has been received.

TOP BACK

This section is only for Tier IIs.

TOP BACK

Medicare is aware that there may be problems processing some disenrollments and is working to correct them. I will forward your information to the Centers for Medicare and Medicaid Services (CMS). Once your disenrollment information has been updated in our system, which takes about 15 business days, your provider should resubmit the claim to Medicare for processing. I apologize for any inconvenience this may have caused you.

****CSR NOTE**: Complete the MA Disenrollment Log.**

This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut H at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment dates match date on letter			Click here
Disenrollment dates are same but do not match date on letter			Click here

TOP BACK

This section is only for Tier IIs.

TOP BACK

CSR NOTE: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD." In the Issue/Complaint field, note that the caller says a confirmation letter has been received.**

TOP BACK

This section is only for Tier IIs.

TOP BACK

Our system is showing a disenrollment date of [insert date]. Please call your plan to verify your disenrollment date.

TOP BACK

This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut I at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment date is the same			Click here
Disenrollment dates are not consistent			Click here
Disenrollment date shown	No disenrollment date shown	No disenrollment date shown	Click here
Disenrollment date is the same		No disenrollment date shown	Click here
Disenrollment date shown	No disenrollment date	Disenrollment date shown	Click here
No disenrollment date	No disenrollment date	No disenrollment date	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

TOP BACK

This section is only for Tier IIs.

TOP BACK

Are you being denied emergency care because your provider shows that you are still enrolled in a Medicare Advantage Plan?

YES	NO

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This section is only for Tier IIs.

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In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut J at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action

Disenrollment date is the same			Click here
Disenrollment dates are not consistent			Click here
Disenrollment date shown	No disenrollment date shown	No disenrollment date shown	Click here
Disenrollment date is the same		No disenrollment date shown	Click here
Disenrollment date shown	No disenrollment date	Disenrollment date shown	Click here
No disenrollment date	No disenrollment date	No disenrollment date	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

TOP BACK

This section is only for Tier IIs.

TOP BACK

CSR NOTE: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD."

TOP BACK

This section is only for Tier IIs.

TOP BACK

Did you receive a letter confirming your disenrollment?

YES	NO

TOP BACK

This section is only for Tier IIs.

TOP BACK

What is the date on your letter? Is the date on the letter correct?

YES	NO

TOP BACK

This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut K at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment dates match date on letter			Click here
Disenrollment dates do not match date on letter			Click here
Disenrollment date matches letter	No disenrollment date or date doesn't match letter	No disenrollment date or date doesn't match letter	Click here
Disenrollment date matches letter		No disenrollment date or date doesn't match letter	Click here
No disenrollment date	No disenrollment date	No disenrollment date	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut L at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment dates match date on letter			Click here
Disenrollment dates are same but do not match date on letter			Click here

TOP BACK

This section is only for Tier IIs.

TOP BACK

**Review Activities applet to verify when disenrollment was requested.*

- **If disenrollment effective date is the first of the month following the disenrollment request, READ:**
  Our records show that you requested to disenroll on [insert date], and therefore, the effective date is correct.

- **If disenrollment effective date is later than the first of the month following the disenrollment request date:**
  CSR NOTE: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD."

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****This section is only for Tier IIs.****

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Our system shows that your disenrollment was effective on [insert date]. I can send you a letter confirming your disenrollment date, which you will receive within 7 to 10 business days. Please ask your provider to resubmit the claim.

****CSR NOTE**: Complete the Duplicate Letter Request Email Template.**

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This section is only for Tier IIs.

TOP BACK

In the Enrollment Compare tab, check the MA PDP Enrollment, Medicare Advantage CWF System, and Medicare Advantage Data Repository applets. When you return to this script, click Shortcut M at the top.

MA PDP Enrollment	Medicare Advantage CWF System	Medicare Advantage Data Repository	Action
Disenrollment date is the same			Click here
Disenrollment dates are not consistent			Click here
Disenrollment date shown	No disenrollment date shown	No disenrollment date shown	Click here
Disenrollment date is the same		No disenrollment date shown	Click here
Disenrollment date shown	No disenrollment date	Disenrollment date shown	Click here
No disenrollment date	No disenrollment date	No disenrollment date	Click here
No plan is listed	Plan is listed	Plan is listed	Click here
Plan listed (no date)	No plan is listed	No plan is listed	Click here
No plan is listed	No plan is listed	No plan is listed	Click here

This section is only for Tier IIs.

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**Check Activities applet to verify date disenrollment was requested.

- **If more than 15 business days:**
  ****CSR NOTE**: Complete PDP Plan Referral survey requesting a retroactive disenrollment using "MA-RD."**
- **If less than 15 business days, READ:**
  Please allow up to 15 business days for your disenrollment request to be processed. Once your request is processed, you will receive a letter confirming your disenrollment or stating why it was denied.
- **If nothing is in Activities, READ:**
  Please contact your plan for the status of your disenrollment.

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Disenrollment Cancellation

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If you enroll, switch, or disenroll but change your mind **before the change goes into effect**, you must call your plan to cancel the enrollment or disenrollment request. If applicable, you should also contact the plan that you want to stay in. Once your plan becomes effective, you must wait until your next valid enrollment period (special or annual) to make changes to your coverage.

If the caller wants us to try to cancel the disenrollment, transfer to a Tier II.

Tier I CSRs:
I am going to transfer you to a Medicare Benefits Specialist who may be able to help you with your cancellation request. You may be asked to repeat some of your personal information. I am going to transfer your call now. Please do not hang up. There may be a period of silence before the Medicare Benefits Specialist answers.

Tier II CSRs:
CLICK HERE for the cancellation process.

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This section is only for Tier IIs.

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READ:
I will check our system to see if I can cancel your disenrollment. If the disenrollment is no longer pending in our system, you will have to call the plan to cancel the request. Once the disenrollment is effective, you must wait until your next valid enrollment period to make changes to your coverage.

****CSR NOTE**: Use the MA PDP Disenrollment tab and highlight the record to be cancelled to verify that it is Pending. If it is Pending, click the Cancel Request button. If it is not pending, refer the caller to the plan to have the disenrollment cancelled.**

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Enrollment Reconciliation

TOP BACK

Use the script "Plan Enrollment Reconciliation."

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Marketing Misrepresentation

TOP BACK

If the caller's record has an Employer Subsidy through West Virginia Public Employees that ended on 6/30/2007 AND/OR an enrollment into Advantra Freedom offered by Coventry (H5227, PBP 802) with an effective date of 7/1/2007, CLICK HERE.

Otherwise, continue with the information below.

DO NOT READ THE FOLLOWING TO THE CALLER

Some examples that would be considered misleading or incorrect information include:

- Statements that indicate or suggest that the plan is accepted by all providers in the area who accept Medicare.
- Statements that describe the product as a Medigap policy or "Med Supp" plan that supplements Medicare.
- Statements to potential enrollees that indicate or suggest that they can switch back to their other plan or Original Medicare "at any time" or outside of existing enrollment periods.
- Other misleading or incorrect statements made by plan employees, agents, or brokers or in plan materials that are designed to entice beneficiaries to enroll in the plan.

Some examples that would not be considered to be incorrect or misleading information:

- The beneficiary wants to disenroll from the plan, without any specific allegation about misleading or incorrect information.

- The beneficiary uses a provider (or group of providers) who previously participated in the plan but no longer does so, assuming that access to services still exists.

CSR NOTE: There is no time restriction on this SEP. Regardless of how long ago the beneficiary feels that he or she was misled, you can still make the change that the caller is requesting.**

Does the caller qualify for the SEP based on the information listed above? If you are not sure, please click the "NO / NOT SURE" button.

YES	NO / NOT SURE

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West Virginia Coventry Advantra Freedom PFFS

TOP BACK

Do not enroll the caller into another plan or process a disenrollment without first using the script, "Drug Coverage West Virginia Coventry Advantra Freedom PFFS H5227."

TOP BACK

Marketing Misrepresentation

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READ:
Based on the information you provided, you may be able to switch or disenroll from your plan because you may be eligible for a special enrollment period. I can make the change that you are requesting today. It will be effective on the first day of the next month. You will be getting information from your plan within the next 14 days.

****TIER I AND TIER II CSR NOTE:** In order to process the caller's request, you will need to do one of the following. If the caller is in a PFFS Plan or Cost Plan and a stand-alone PDP is involved in the switch, you may need to do both. CLICK HERE for an explanation.

1. Submit an enrollment request using the online enrollment center (OEC). Insert the phrase "1-800-Medicare Marketing Misrepresentation SEP" into the "For CMS Use Only" comment box. Enter the OEC confirmation number into the Drug Plan Finder Confirmation # field in NGD.
   ****If the "Enroll Now" button is not available for the plan the beneficiary wants because the plan is not participating in the online enrollment, CLICK HERE.****

2. Transfer to a Tier II to process the disenrollment, if applicable. **If you enrolled the caller into a plan, enter the plan name and contract number into the CSR Comments field in NGD.**
   ****Tier IIs ONLY: CLICK HERE for the disenrollment process.** If the caller wants a retroactive change, return to this section of the script after processing the disenrollment (and see below for instructions). **You should NOT submit a retroactive disenrollment, which is called an MA-RD (MA RETRO DISENROLLMENTS) or**

PDP-RD (PDP RETROACTIVE DISENROLLMENTS).**

****TIER I AND TIER II CSR NOTE: If the caller requests a retroactive change**, warm transfer to the Help Queue and explain that the caller qualifies for the MA marketing misrepresentation SEP and is requesting a retroactive change. The Help Queue will submit this as an **Enrollment Exception (EE)** by using the script in the PDP Plan Referral Survey.

- If you submitted an enrollment, provide the plan name and contract number to the Help Queue.
- If you processed a disenrollment, explain to Help Queue all actions that were taken during the call, including any enrollments or disenrollments (including any actions taken by another CSR).

The **Help Queue agent** needs to enter the "Bypass" Code and NOT the contract number into the Complaint Contract Number field. Help Queue should follow the "Plan Complaints" script in the PDP Plan Referral Survey for additional instructions regarding this EE.

TIP BOX:

TRANSFER = Tier II (Medicare Benefits Specialist)
TIP = There is no time restriction on this SEP. Regardless of how long ago the beneficiary feels that he or she was misled, you can still make the change that the caller is requesting.

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Marketing Misrepresentation

TOP BACK

Do not read any of the following to your caller.

****CSR NOTE:** Call the Help Queue. You should remain in queue until an actual agent is reached. DO NOT perform a blind transfer. **Tell the Help Queue** that you are transferring the call because you do not think this qualifies or you are not sure if this qualifies for the SEP reason that says:

> "You were **misled into joining a Medicare Advantage Plan** (with or without drug coverage) when you thought you were joining a different type of plan. You want to disenroll or switch to the plan you originally wanted."

The Help Queue agent will take ownership of the call. As long as the caller feels that he or she was misled, Help Queue should take ownership. It is not the CSR's responsibility to decide if the situation is really misleading.

TIP BOX:

TRANSFER = Help Queue

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"Enroll Now" button is not available

TOP BACK

****If the "Enroll Now" button is not available for the beneficiary's plan of choice, READ**: The plan you want to enroll in does not participate in online enrollment. I will be transferring you to another Customer Service Representative who will gather some information from you to submit your enrollment request. Please hold while I transfer you now.

****CSR NOTE**: Warm transfer to Help Queue to file an Enrollment Exception (EE). Explain that you used the script "Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage." **You must provide the following information to the Help Queue**:

> "The beneficiary wants to enroll into [PLAN NAME], which is [CONTRACT NUMBER]. However, the plan does not participate in online enrollment in the CSR Plan Finder Tool."

The Help Queue agent will take ownership of the call. As long as the caller feels that he or she was misled, Help Queue should take ownership. It is not the CSR's responsibility to decide if the situation is really misleading.

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America's Health Choice Plan Termination

TOP BACK

Use the script "America's Health Choice Plan Terminations" if the caller is affected by the termination of America's Health Choice Plan (H1034 or S9086).

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If the caller is in:	The following is required:
Private Fee-for-Service (PFFS) Plan and a stand-alone prescription drug plan (PDP)	Two separate actions*
Cost Plan and a stand-alone PDP	Two separate actions*

****CSR NOTE**: Two separate actions mean that the two parts act independently of each other. Changes to one plan (for example, the stand-alone PDP) will not affect the other plan (for example, the PFFS Plan).

For example, if the caller wants to return to Original Medicare without drug coverage, two separate disenrollments are needed - one for the PFFS or Cost Plan and one for the stand-alone PDP.****

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Medicare Secondary Payer (MSP)

START: Click the link that applies to the caller's question.

What is MSP?	How does MSP work?
Initial Enrollment Questionnaire	Report Retirement / Changes to Primary Insurance
Claim Denied - Records Show Medicare is Secondary When it Should Be Primary	

TOP BACK

Click the link that applies to the caller's situation.

****CSR NOTE:** Ask caller what other type of coverage they have in addition to Medicare. For example:

- Have they been in a car accident (No-Fault Liability or Liability Insurance)?
- Were they injured at work (Workers' Compensation)?
- Did the caller's employer coverage recently end (COBRA)?

65 + Working (Beneficiary or Spouse)	**65 + NOT Working (Covered by Retiree Plan)**	**Disabled Under 65 (Covered by Group Health Plan)**
COBRA	**Veterans Affairs (VA) Health**	**TRICARE for Life**
No-Fault or Liability Insurance	**Workers' Compensation**	**Medicaid**

ESRD (End Stage Renal Disease) with or without COBRA

Black Lung Disease

Retired Federal Employees

Paying Deductibles when Medicare is Secondary

What Is MSP?

TOP BACK

Sometimes you may have other insurance that pays your health care bills first and Medicare pays second. This is called Medicare Secondary Payer (MSP).

Insurance that may have to pay first includes:

- Employer group health plan insurance under certain conditions,
- No-fault insurance (e.g., auto or homeowners),
- Liability insurance (e.g., homeowners, auto, malpractice),
- Black lung benefits, or
- Workers' compensation.

This applies no matter how you get your Medicare benefits. It could be through Original Medicare, a Medicare Advantage Plan, or a Medicare Private Fee-for-Service Plan. Tell your doctor, hospital, and all other health care providers about your other insurance coverage.

You will need to make sure that your bills are sent to the correct payer to avoid delays and inappropriate primary payment by Medicare.

- **No-fault insurance** is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.
- **Liability insurance** is coverage that pays for health care services resulting from injury to you or damage to your property. It also confirms who is at fault for causing the accident.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

CSR TIPS

REFERRAL = The Coordination of Benefits Contractor for help in filling out MSP development letters or questionnaires.

SCRIPT = MP MSP Supplemental Crossover of Claims to answer general questions about the crossover of claims to supplemental insurers.

END

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Initial Enrollment Questionnaire

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Initial Enrollment Questionnaire:
You should receive an Initial Enrollment Questionnaire shortly after receiving your Initial Enrollment Packet (about three months before you are entitled to Medicare). The questionnaire will ask you if you have other health insurance coverage.

The questionnaire provides a record for Medicare of a secondary payer before an actual first claim is filed.

It is important that you fill it out and send it back to the Coordination of Benefits Contractor.

Payment for your medical bills may be delayed if you don't send the questionnaire back.

If you are disabled, you will also get this questionnaire to establish the types of insurance coverage you may have.

Medicare First Claim Development Letter:
If you do not fill out the Initial Enrollment Questionnaire and a claim is filed, a **First Claim Development letter** will be sent to you.

This is a questionnaire that must be returned in order for your claims to be processed.

The purpose of the First Claim Development letter is to make sure that Medicare pays your claims correctly. Also, Medicare wants to ensure that any payments made on your claims are coordinated with payments made by your other insurance.

Medicare Employee Group Health Plan Development Letter:
This questionnaire collects information about employer group health insurance to determine secondary payer status for Medicare.

Medicare Trauma Code Development Letter:
You are sent a Trauma Code Development letter whenever a claim is received that indicates you were involved in an accident, injury, or illness.

This questionnaire collects information on other types of insurance that may pay for your medical services, such as Workers' Compensation or liability insurance.

CSR TIPS

REFERRAL =

- Coordination of Benefits Contractor if the caller needs a replacement Initial Enrollment Questionnaire, or needs help filling out the questionnaire. Also refer to Coordination of Benefits Contractor if the caller lost his or her Medicare Trauma Code Development letter or has questions about the letter.
- SSA, if caller has changed his or her address.

REFERENCE MATERIAL = Initial Enrollment Questionnaire

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Original Contractor / COB Contractor Numbers

Original Contractor / COB Contractor Numbers	READ
11100 = COB Contractor	We received information from the COB Contractor.
11101 = Initial Enrollment Questionnaire	We received your Initial Enrollment Questionnaire that has information about your other insurance.

11102 = IRS/SSA/CMS Data Match	We received information from the Internal Revenue Service (IRS) or the Social Security Administration (SSA) or the Centers for Medicare and Medicaid Services (CMS).
11104 = Litigation Settlement	We received information from a litigation settlement.
11105 = Employer Voluntary Reporting	We received information from a current or former employer. ****CSR NOTE:** Each month, the employer sends the updated information to the Centers for Medicare and Medicaid Services (CMS) to update the employee's records. When there is a change to an employee's insurance, this information is updated in our system based on the information from the employer. This explains why a closed MSP file has been reopened a number of times.**
11106 = Insurer Voluntary Reporting	We received information from an insurer.

11107 = First Claim Development	We received your First Claim Development letter. This is the letter that you returned to us in order for your first claim to be processed. ****CSR NOTE:** This letter is sent out to the beneficiary only if COB Contractor did not receive the Initial Enrollment Questionnaire.
11108 = Trauma Code Development	We received information from a Trauma Code Development letter. This letter is sent when a claim is submitted to Medicare with a diagnosis that indicates a possible traumatic accident, injury, or illness.
11109 = Secondary Claims Investigation	We received information from a secondary insurer.
11110 = Self Reports	We received information from the primary insurance holder.
11112 = Blue Cross-Blue Shield Voluntary Data Sharing Agreement	We received information from a current or former employer or an insurer.
11113 = Office of Personnel Management (OPM) Data Match	We received information from the Office of Personnel Management.

11114 = State Workers' Compensation (WC) Data Match	We received information from the State Workers' Compensation file.
11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)	We received information from the State Workers' Compensation file.
11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)	We received information from a litigation settlement.
11117 = Voluntary Data Sharing Agreements (No Fault VDSA)	We received information from a litigation settlement.
11118 = Pharmacy Benefit Manager Data	We received information from your plan's pharmacy benefit manager.
11125 = Recovery Audit Contractor-California	We received information from the California Recovery Contractor. ****CSR NOTE:** California has an audit contractor to determine if a patient's primary insurer and Medicare have both been billed for a single claim or if Medicare paid when a patient's primary insurer should have paid.

11126 = Recovery Audit Contractor- Florida	We received information from the Florida Recovery Contractor. **CSR NOTE:** Florida has an audit contractor to determine if a patient's primary insurer and Medicare have both been billed for a single claim or if Medicare paid when a patient's primary insurer should have paid.
Other	I'm sorry, I am unable to determine who made the update to your record.

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****CSR NOTE**; Follow the instructions in the attached chart to determine the appropriate referral to close an open MSP record or to change a termination date for MSP other than Working Aged.

If the record shows that Medicare is NOT primary (is secondary) and the primary insurance is...	Referral
• COBRA (with ESRD) • Disability insurance through a Group Health Plan • Federal Black Lung Program	**REFERRAL** = COBC
• Federal Employees Health Benefits	**REFERRAL** = Office of Personnel Management (OPM)

• No-Fault or Liability Insurance - Claims denied for Liability MSP, but the beneficiary states that the claim is unrelated to the accident or injury.	****CSR NOTE**: Transfer to the appropriate Tier I Claims CSR. **Claims CSR click here for more information**.
• All other No-Fault or Liability Insurance Issues	**REFERRAL** = Medicare Secondary Payer Recovery Contractor (MSPRC)
• TRICARE for Life	**REFERRAL** = DEERS Support Office at the Department of Defense
• Veterans Affairs (VA) Health	**REFERRAL** = Department of Veterans Affairs
• Workers' Compensation - Claims denied for Workers' Compensation MSP, but the beneficiary states that the claim is unrelated to the accident or injury.	****CSR NOTE**: Transfer to the appropriate Tier I Claims CSR. **Claims CSR click here for more information**.
• All Other Workers' Compensation	**REFERRAL** = MSPRC

CLICK HERE to assist beneficiaries with navigating the COBC IVR.

Report Retirement / Changes to Primary Insurance

Claims Denied - Record Shows Medicare is Secondary When it Should be Primary

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To report NEW Medicare Secondary Payer cases, refer to the Coordination of Benefits Contractor (COBC). For any other changes, or for denied claims, follow the steps below.

1. Identify the open MSP instance(s) (if any) using the BCC Tier 1 view and go to the Insurance tab.
2. Look in the MSP form applet to view any open records and identify the type of MSP (e.g., working aged, disabled, liability, etc).

****CSR NOTE:** The MSP view defaults to **open cases**. The Show Open button displays only the open records, and the Show All button displays all MSP records.

Are there any open MSP instances in CWF?

- **YES - WORKING AGED**
  - If Working Aged and Validity = I, **refer** to the COBC. **CLICK HERE** for COBC timeframe.
  - If Working Aged and caller says their record is not correct (they never had the MSP instance), **refer** to the COBC to have the record deleted.
  - If Working Aged, there is a valid record that just needs to be closed (and does not have validity = I), then Gen Med CSRs **CLICK HERE** for transfer information.
- **YES -** Insurance Other Than Working Aged**, CLICK HERE**
- **NO -** There are **NO OPEN MSP** Instances in CWF, click the Show All tab to view any other MSP records:
  - If there is a record with no termination date, and the record is deleted or invalid, **CLICK HERE**
  - If there is a record with a termination date, verify that date with the caller. If correct, **CLICK HERE**
    - If the termination date is incorrect for a Working Aged record, **refer** to the COBC to correct the date.
    - For all other MSP types, **CLICK HERE**

****CLAIMS CSRs only, CLICK HERE for more information.****

CLICK HERE to assist beneficiaries with navigating the COBC IVR.

No Open MSP Records in BCC Tier 1 View

TOP BACK

READ: Your insurance information has been updated. If you have a claim that was denied, ask your physician, supplier, or facility to resubmit the claim.

If the MSP instance has a future termination date, also **READ**: Your current insurance will be primary until [read the termination date].

****CSR NOTE:**

- If the caller indicates that his or her MSP has been reopened a number of times and wants to know how and why this keeps happening, **transfer to Tier I Claims CSR**.
- If the caller indicates that his or her claims are continuing to be denied even though the insurance information has been updated, go to the BCC Tier 1 view to load the claim and click on Claims tab to see if any recent claims have been paid. If there are any recent claims that

have been paid, **READ**: Your can ask your physician, supplier, or facility to resubmit the claims that were denied.

- If there are no recent claims that have been paid, **transfer to Tier I Claims CSR**.

TOP BACK

Claims CSR Information

TOP BACK

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Determine the caller's situation and click on the appropriate link for instructions:

- **Open MSP record for beneficiaries who are working aged, retired or have Terminated their insurance**
- **MSP record was closed but has reopened**
- **No open MSP instances but claims still deny**
- **Claims denied for Workers' Compensation or Liability MSP, but beneficiary states that the claim is unrelated to the accident or injury**
- **UnitedHealthcare incorrectly showing as the primary insurance instead of Medicare**

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Claims CSR Information

Open MSP Record for Beneficiaries (including Railroad Retirement Board [RRB] beneficiaries) who are Working Aged, Retired or have Terminated their Insurance

1. If the call started on the BCC Tier 1 view, go to the Beneficiaries screen and requery with the Medicare Number and the Part B contractor ID.
   - If the call did not start on the BCC Tier 1 view, requery with the Medicare Number and the Part B contractor ID on the Beneficiaries screen.

     If you can't find the Part B contractor ID, use the Agent Partner Search tab to find the number for the Part B carrier that handles the beneficiary's state. You can also click on the field control within the Contract All field to search for the Part B contract ID.

2. Go to MSP view and click on Show More button, query for the Part B contractor ID in the Contractor Number field and click on the Load MSPs button.

3. If there is **NO** open MCS MSP instance record, refer to the Coordination of Benefits Contractor (COBC). If there is an open MSP record, proceed to step 4.

4. Select the open MCS MSP instance record.

5. Check to see if the Insurer Number field is blank before updating the primary insurance termination date. If the Insurer Number field is blank, refer the caller to the COBC.

   - For Part B (MCS) updates, enter the following fields into the MSP list applet and save the record by clicking the Update Termination Date button:

- Termination Date (****CSR NOTE:** If the caller doesn't know the end date of employment, refer the caller back to his or her employer. The termination date cannot be more than six months in the future from the current date. If the person calls to report a retirement date that is more than six months in the future, then you must tell the caller to call back. Also, the termination date should not be before or on the day of the effective date. For example, if the effective date is July 10, 2006 the termination date should not be July 10, 2006 or any time before July 10, 2006.)

READ: Your record has been updated to show Medicare as primary. You can ask your physician, supplier, or facility to resubmit the claim in 15 business days.

****CSR NOTE:** It is possible for beneficiaries to have more than one current valid MSP record. For example, they may have employment-based coverage and also liability coverage as a result of an auto accident. Look at the MSP Type and Insurer information to understand these types of situations and to identify which record(s) may need to be updated.

If you receive an Error Message, Click Here.

TOP BACK

Claims CSR Information

MSP Record was Closed but has Reopened

TOP BACK

Using the Beneficiaries view, click on the MSP tab. Look for the CWF MSP instance that has been **reopened**.	**CSR NOTE:** The MSP view defaults to open cases. The Show Open button displays only the open records, and the Show All button displays all MSP records.

Check Detailed applet to find the Original Contractor Number.	**CLICK HERE** to locate the Original Contractor/COB Contractor number in the table.
Provide the source of MSP information to the caller.	If the MSP source is their employer, tell the beneficiary to contact them directly to so that the employer can update their records. This will prevent future reopenings.

TOP **BACK**

Claims CSR Information

No Open MSP Instances but Claims Still Deny

TOP BACK

Using the Beneficiaries view, click on the MSP tab. ****CSR NOTE**: You will need to click the Show All button. ****CSR NOTE**: You do not need to requery with the contractor ID because you only need to look at the CWF record.	Look for the CWF MSP instance that has been **closed** most recently and note the date of that action. (Check Detailed applet Last Update or Last Maintenance Date).

Using the BCC Tier 1 view, click on the Claims tab and check recent claims activity for all claims types (select CWF category “all”).	Determine whether any claims have denied after the MSP record was updated by comparing the MSP last update date, to the date the claims were processed (accretion date).

CLICK HERE after completing instructions above.

TOP **BACK**

Claims CSR Information

No Open MSP Instances but Claims Still Deny

TOP BACK

DETERMINE WHICH OF THE FOLLOWING APPLY:

No claims have processed (accreted) after the MSP last update date.	**READ:** Your insurance information has been updated. If you have a claim that was denied, ask your physician, supplier, or facility to resubmit the claim.

Claims were processed and have been paid after the MSP last update date.	**READ:** Your insurance information has been updated and claims are being processed and paid. If you have a claim that was denied, ask your physician, supplier, or facility to resubmit the claim.
Claims were processed and continue to deny after the MSP last update date **This step is necessary **only** if claims continue to be denied after the CWF MSP record has been updated.** ****CSR NOTE:** Please enter the information into the Feedback tool if this situation occurs.	Determine which local contractor's system is denying claims. If the denial reason was MSP: ****TIER I CLAIMS CSR:** Escalate to the appropriate PART B/MAC contractor as a complex inquiry using the Escalation Type field located on either the Contacts, Beneficiaries, or Activities screen. ****TIER II CLAIMS CSR:** Escalate to the appropriate PART B/MAC contractor as a complex inquiry using the Escalation Type field located on either the Contacts, Beneficiaries, or Activities screen. If the denial reason was not MSP, tell the caller the reason the claim was denied. .

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Claims CSR Information

Claims denied for Workers' compensation or Liability MSP, but beneficiary states that the claim is unrelated to the accident or injury

****CSR NOTE**: If you have verified that the claim was denied for Workers' compensation or Liability MSP and the beneficiary states that the claim is unrelated to the accident or injury, please follow the steps listed below:

- ****TIER I CLAIMS CSR**: Escalate to the appropriate FFS/MAC contractor as a complex inquiry using the Escalation Type field located on the Contacts, Beneficiaries, or Activities screen. Please include a detailed comment in the CSR Comments field that states: "The beneficiary is stating that the denied claim is unrelated to the accident or injury and we are sending the information for further research. If the research supports what the beneficiary stated (denied claim is unrelated to the accident or injury), please override the claim denial."

- ****TIER II CLAIMS CSR**: Escalate to the appropriate FFS/MAC contractor as a complex inquiry using the Escalation Type field located on the Contacts, Beneficiaries, or Activities screen. Please include a detailed comment in the CSR Comments field that states: "The beneficiary is

stating that the denied claim is unrelated to the accident or injury and we are sending the information for further research. If the research supports what the beneficiary stated (denied claim is unrelated to the accident or injury), please override the claim denial."

- Enter the information into the Feedback tool under the category General Medicare/Government Comments. Your feedback submission must include the:
  - HICN
  - Contractor ID for denied claim
  - Claim Number of denied claim
  - Date of service

TOP BACK

Claims CSR Information

UnitedHealthcare incorrectly showing as the primary insurance instead of Medicare

We are aware of an issue in which UnitedHealthcare is incorrectly showing as the primary insurance for some people with Medicare. UnitedHealthcare is also aware of this issue and is working to update the records. If you had claims denied because of this issue, please wait until your records have been updated and then ask your provider to resubmit your claim(s) to Medicare.

****CSR NOTE: Read only if the caller asks how long it will take to have the records updated.** It should take about 2-3 weeks (after the week of October 1) to have the records corrected.

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EE Special Enrollment Period for Working Aged

TOP BACK

The Special Enrollment Period is available if you waited to enroll in Medicare Part B because you or your spouse was working **and** had group health coverage through a current employer or union. If this applies, you can sign up for Medicare Part B:

- While you are still covered by an employer or union group health plan, through your or your spouse's employment, or
- During the eight months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever comes first).

If you are working and plan to keep your employer's group health coverage, talk to your benefits office to help you decide when to enroll in Part B. When you sign up for Part B, you automatically begin your Medigap open enrollment period. Once this period begins, it cannot be changed or restarted.

If you are disabled and working (or you have coverage from a family member), the Special Enrollment Period rules may also apply.

Most people who sign up for Part B during the Special Enrollment Period do not have to pay higher premiums. However, if you're eligible for Part B and do not sign up during the Special Enrollment Period, you will be able to sign up only during the General Enrollment Period and the cost of Part B may go up.

ADDITIONAL INFORMATION:
You can sign up for Part B at your local Social Security office.

If you dropped Part B because you or your spouse (or family member, if you are disabled) returned to

work and had group health coverage, you can sign up again during the Special Enrollment Period. The cost of Part B will not go up. You will not get another Medigap open enrollment period when you restart Part B. Make sure your group coverage is in effect before you drop Part B.

I can access the Medicare Eligibility tool which will give me information specific to your situation. Would you like me to do this now?

IF YES, READ SCRIPT: "CS Medicare.gov Tools" and click on "Medicare.gov Eligibility Tool", then launch to Eligibility tool.

CSR TIPS

TIP = If you do not enroll during the Special Enrollment Period, you can enroll during the General Enrollment Period. This may delay your Part B start date and you may have to pay a higher premium amount. The premium surcharge will apply as long as you have Part B, not just the first year of enrollment.

REFERRAL = SSA

WEB = www.socialsecurity.gov

FULFILLMENT =

- Enrolling in Medicare (information about Medicare Special Enrollment Period) - #11103

END

TOP BACK

Verify if the person with Medicare is in the first 30 months of eligibility or is entitled to Medicare

First 30 Months / After 30 Months

****CSR NOTE:** The 30-month coordination period starts the first month you are able to get Medicare because of kidney failure, even if you are not enrolled in Medicare yet.

TOP BACK

Verify if the caller also has COBRA coverage.

Yes / No

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Verify if the caller also has COBRA coverage.

Yes / No

TOP BACK

Medicare and Medicaid Coordination

TOP BACK

Pays First

Medicare

Pays Second

Medicaid

If you have both Medicare and Medicaid, your claim should be sent to Medicare first for services that Medicare covers. The part of the bill that Medicare does not pay will then be sent to your state Medicaid program for further payment.

CSR NOTE: Dual eligible people are entitled to Medicare (Part A and/or Part B) and are also eligible for Medicaid.

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Refer to State Medicaid Office to answer specific questions about Medicaid coverage • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Script • **MP MSP Supplemental Crossover of Claims** to answer general questions about the crossover of claims to supplemental insurers.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

REFERRAL =

- State Medicaid Department if his or her record does not show he or she has Medicaid.
- State Health Insurance Assistance Program (SHIP) for counseling. SHIP provides a broad range of services, including counseling on Medicare private plan options, Medicare appeals, COB, and low income assistance.

TOP BACK

MSP Over 65 with Medicare and Working (Beneficiary or Spouse)

TOP BACK

Verify if the employer has more than 20 employees:

More than 20 employees

Fewer than 20 employees (or, if your employer is part of a multi-employer plan where any of the employers have 20 or more employees and the plan has filed a request for an exemption that is approved by Medicare).

If your employer has 20 or more employees, Medicare is the secondary payer on hospital and medical bills. If your group health plan did not pay the entire bill, the provider should send the bill to Medicare for secondary payment.

You also may want to wait to enroll in Medicare Part B if you have health coverage through an employer or a union through your or your spouse's current or active employment.

If you **reject** the plan, Medicare will be your primary insurance and will pay its share of any Medicare-covered health care service you receive. Your employer can't offer to pay for a plan that supplements Medicare. However, an employer may offer a plan that pays for health care not covered by Medicare (such as hearing aids, dental, and/or routine physical exams).

****CSR NOTE:** For questions about special enrollment, see script: **EE Special Enrollment Period for Working Aged.**

CSR TIPS

REFERRAL =

- State Health Insurance Assistance Program (SHIP) for assistance with your plan options.
- Employee Health Plan Benefit Office for information about your employer's plan.
- Coordination of Benefits Contractor to report a change in employer size.

WEB = Your Guide to Who Pays First - #02179

END

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Verify if the employer has more than 100 employees:

More than 100 employees, or

Fewer than 100 employees

TOP BACK

MSP Over 65 with Medicare and Working (Beneficiary or Spouse) - More than 20

TOP BACK

Pays First

Group Health Plan

Pays Second

Medicare

If your employer has 20 or more employees, Medicare is the secondary payer on hospital and medical bills. If your group health plan did not pay the entire bill, the provider should send the bill to Medicare for secondary payment.

Medicare will review what your group health plan paid for Medicare-covered services, and pay any additional Medicare-approved amounts. You may have to pay the costs of services that Medicare or the group health plan doesn't cover.

If your group health plan paid more than Medicare's allowance, Medicare will not make any secondary payment on the claim. You will have to pay the remaining amount after your group health plan has paid, unless you have a third insurance.

If you are age 65 or over, and have employer or union health benefits based on your or your spouse's current or active employment, you may keep or reject coverage from your employer. If you **keep** your employer or union coverage, employers with 20 or more employees must offer the same health benefits, under the same conditions, to current employees age 65 and over as they would offer to younger employees. If the employer offers coverage to the spouses, they must offer the same coverage to spouses age 65 and over that they offer to spouses under age 65.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• For help in filling out MSP development letters or questionnaires. • Report change in employer size.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.

Associated Scripts

- **MP MSP Supplemental Crossover of Claims** to answer **general** questions about the crossover of claims to supplemental insurers.
- **EE Special Enrollment Period for Working Aged**

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

REFERRAL =

- State Health Insurance Assistance Program (SHIP) for assistance with your plan options.

- Employee Health Plan Benefit Office for information about your employer's plan.

WEB = Your Guide to Who Pays First - #02179

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ESRD and COBRA- First 30 Months with COBRA Coverage

TOP BACK

Pays First

COBRA

Pays Second

Medicare

COBRA is a law that allows you to keep your employer group health plan coverage for a limited period of time after your employment ends. This coverage includes all dependents who are covered under the cancelled policy.

This is called **continuation coverage** and applies only to those employers with **20 or more employees**. If you have ESRD and COBRA coverage, COBRA pays first during your first 30 months of eligibility or entitlement to Medicare, and Medicare pays second.

COBRA and Special Enrollment Period:
Even if you get COBRA coverage when your employment ends, you should still consider enrolling in Medicare Part B at the same time because you won't get another Special Enrollment Period. The Special Enrollment Period means you will have to sign up for Medicare Part B within eight months after you lose your group health plan coverage or you will have to pay a higher Part B premium if you enroll at a later time.

COBRA and Employer Requirements:
If you are age 65 or older and you are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before your employment ends or before you lose your employer's coverage. If you wait to sign up for Medicare Part B during the eight months after your employment or coverage ends, you may have to pay for your services during the time that you were without coverage. Signing up for Part B before your employer coverage ends will ensure that you don't miss a day of coverage.

Before you elect COBRA
Before you elect COBRA coverage, it may be helpful to talk with the State Health Insurance Assistance Program (SHIP) about whether buying a Medigap policy would be better for you than electing COBRA coverage.

COBRA and Medicare
If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if you enrolled in Medicare after the date you elected COBRA coverage.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• Report COBRA coverage. • MSP Secondary Claim development questionnaires or letters. • Report change in employer size.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim where there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Scripts • **CS ESRD Basic Information** - click on “Coordination of Benefits” for more information on ESRD and coordination of benefits. • **MP MSP Supplemental Crossover of Claims** to answer general questions about the crossover of claims to supplemental insurers.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

REFERRAL =

- State Insurance Department.
- State Health Insurance Assistance Program (SHIP) for counseling. SHIP provides a broad range of services, including counseling on Medicare private plan options, Medicare appeals, COB, and low income assistance.

WEB = www.dol.gov for more information on COBRA

WEB = Your Guide to Who Pays First - #02179

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ESRD without COBRA- First 30 Months without COBRA Coverage

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Pays First

Group Health Plan

Pays Second

Medicare

For more information on ESRD and coordination of benefits, go to script "**CS ESRD Basic Information**" and click on “Coordination of Benefits.”

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.

Associated Script

- **MP MSP Supplemental Crossover of Claims** for information on secondary insurance payments.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

FULFILLMENT =

- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services - #10128 (currently only available for viewing on www. medicare.gov).

WEB = www.medicare.gov to compare dialysis facilities in your area.

WEB = Your Guide to Who Pays First - #02179

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ESRD without COBRA - After 30 Months without COBRA Coverage

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Pays First

Medicare

Pays Second

Group Health Plan

For more information on ESRD and coordination of benefits, go to script "**CS ESRD Basic Information"** and click on “Coordination of Benefits.”

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Script • **MP MSP Supplemental Crossover of Claims** for information on secondary insurance payments.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

FULFILLMENT =

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ESRD and COBRA- After 30 Months with COBRA Coverage

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Pays First

Medicare

Pays Second

COBRA

COBRA is a law that allows you to keep your employer group health plan coverage for a limited period of time after your employment ends. This coverage includes all dependents who were covered under the cancelled policy.

This is called **continuation coverage** and applies only to those employers with **20 or more employees**. If you have ESRD and COBRA coverage, Medicare pays first after your 30 months of eligibility or entitlement to Medicare and COBRA pays second.

COBRA and Special Enrollment Period:

Even if you get COBRA coverage when your employment ends, you should still consider enrolling in Medicare Part B at the same time because you won't get another Special Enrollment Period. The Special Enrollment Period means you will have to sign up for Medicare Part B within eight months after you lose your group health plan coverage or you will have to pay a higher Part B premium if you enroll at a later time.

COBRA and Employer Requirements:
If you are age 65 or older and you are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before your employment ends or before you lose your employer's coverage.

If you wait to sign up for Medicare Part B during the eight months after your employment or coverage ends, you may have to pay for your services during the time that you were without coverage. Signing up for Part B before your employer coverage ends will ensure that you don't miss a day of coverage.

Before you elect COBRA
Before you elect COBRA coverage, it may be helpful to talk with the State Health Insurance Assistance Program (SHIP) about whether buying a Medigap policy would be better for you than electing COBRA coverage.

COBRA and Medicare
If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if you enrolled in Medicare after the date you elected COBRA coverage.

****CSR NOTE:**

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.

• Report COBRA coverage. • MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

FULFILLMENT =

- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services - #10128 (currently only available for viewing at www. medicare.gov).

WEB = www.medicare.gov to compare dialysis facilities in your area.

WEB = Your Guide to Who Pays First - #02179

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MSP Over 65 with Medicare and Working (Beneficiary or Spouse)- Fewer than 20

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Pays First

Medicare

Pays Second

Group Health Plan

If your employer has fewer than 20 employees, Medicare is generally the primary payer for all people with Medicare enrolled in the group health plan if the plan requests a Small Employer Exception to the MSP rule.

If your group health plan paid more than Medicare's allowance, Medicare will not make any secondary payment on the claim. You will have to pay the remaining amount after your group health plan has paid, unless you have a third insurance.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• For help filling out MSP development letters or questionnaires.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Script • **MP MSP Supplemental Crossover of Claims** for information on secondary insurance payments or to answer general questions about the crossover of claims to supplemental insurers.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

REFERRAL =

- State Health Insurance Assistance Program (SHIP) for assistance with your plan options or how your plan works with Medicare.
- Employee Health Plan Benefit Office for information about your employer's plan.

MSP Disabled Under 65 with Employer Coverage- Fewer than 100 Employees

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Pays First

Medicare

Pays Second

Group Health Plan

If you are **under age 65** and have Medicare because of a disability and also have group health coverage from your employer or from your spouse's employer, Medicare pays **first** if your employer has fewer than 100 employees.

Multi-Employer Plans with fewer than 100 employees:
Sometimes employers with fewer than 100 employees join other employers in a multi-employer plan. If all employers in the multi-employer plan have **fewer than 100 employees**, Medicare pays first. If at least one employer in the multi-employer plan has **100 employees or more**, then Medicare pays second for disabled people with Medicare. Check with your or your spouse's employer's benefits administrator if you are unsure if you have this type of coverage.

****CSR NOTE:**

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR
• For help in filling out MSP development letters or questionnaires. • To report retirement or termination of disability insurance.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Script • **MP MSP Supplemental Crossover of Claims** for information on secondary insurance payments or to answer general questions about the crossover of claims to supplemental insurers.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

WEB = Your Guide to Who Pays First - #02179

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MSP Disabled with Medicare and Retiree Coverage

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Pays First

Medicare

Pays Second

Retiree Coverage

Overview of Retiree Coverage:
Retiree Coverage is group health plan coverage that is provided by your or your spouse's former employer or union. Retiree coverage usually offers benefits that fill in some of Medicare's gaps in coverage and sometimes include extra benefits, such as extra days in a hospital.

****CSR NOTE:** Retiree coverage is not a Medigap policy.

How your plan works after you retire:
Check the price and the benefits, including coverage for your spouse. Make sure you know what effect your continued coverage will have on both your and your spouse's coverage. Retiree coverage provided by your employer or union may have limits on how much it will pay. It may also provide "Stop Loss" coverage or a limit on your out-of- pocket costs. **"Stop Loss" coverage** is a type of insurance that provides certain benefits when a group's total claims during a specified period exceed a specified amount.

If you are not sure how your retiree coverage works with Medicare, get a copy of your plan's benefit booklet provided by your employer or union. You can also call your benefits administrator and ask how the plan works with Medicare.

Generally, when you have retiree coverage from an employer or union they control this coverage. They may change the benefits or the premiums and can also cancel the coverage, if they choose. If you drop your employer or union group health coverage, you may **not** be able to get it back, so please call your benefits administrator for more information.

Keeping Part A and Part B:
When you become eligible for Medicare Part A, you may also need to enroll in Part B to receive full benefits from your retiree coverage. Retiree coverage might not pay your medical costs during any period in which you were eligible for Medicare Part B but didn't sign up for it. Ask your employee benefits administrator if you must have Medicare Part B; some employers require it.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• For help in filling out MSP development letters or questionnaires. • MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Scripts • "Drug Coverage and Other Coverage" for information on how retiree coverage works with the Medicare Drug plans. • **MP MSP Supplemental Crossover of Claims**	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a.m. to 5 p.m. ET Monday through Friday.

REFERRAL = Employee benefits administrator for assistance with your plan options or how your plan works with Medicare.

WEB = Your Guide to Who Pays First - #02179

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MSP Over 65 with Medicare and Retiree Coverage

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Pays First

Medicare

Pays Second

Retiree Coverage

Overview of Retiree Coverage:
Retiree Coverage is group health plan coverage after you retire that is provided by your or your spouse's former employer or union. Retiree coverage usually offers benefits that fill in some of Medicare's gaps in coverage and sometimes include extra benefits.

How your plan works after you retire:
Find out if your employer coverage can continue after you retire. Check the price and the benefits, including coverage for your spouse. Make sure you know what effect your continued coverage will have on both your and your spouse's coverage. Retiree coverage provided by your employer or union

may have limits on how much it will pay. It may also provide "Stop Loss" coverage or a limit on your out-of-pocket costs. **“Stop Loss” coverage** is a type of insurance that provides certain benefits when a group's total claims during a specified period exceed a specified amount.

If you are not sure how your retiree coverage works with Medicare, get a copy of your plan's benefit booklet provided by your employer or union. You can also call your benefits administrator and ask how the plan works with Medicare.

Generally, when you have retiree coverage from an employer or union they control this coverage. They may change the benefits or the premiums and can also cancel the coverage, if they choose. If you drop your employer or union group health coverage, you may **not** be able to get it back, so please call your benefits administrator for more information.

Keeping Part A and Part B:
When you become eligible for Medicare Part A, you may also need to enroll in Part B to receive full benefits from your retiree coverage. Retiree coverage might not pay your medical costs during any period in which you were eligible for Medicare Part B but didn't sign up for it. Ask your employee benefits administrator if you must have Medicare Part B; some employers require it.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.

• MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.

Associated Scripts

- "Drug Coverage and Other Coverage" for information on how retiree coverage works with the Medicare Drug plans.
- **MP MSP Supplemental Crossover of Claims** to answer general questions about the crossover of claims to supplemental insurers.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a.m. to 5 p.m. ET Monday through Friday.

REFERRAL = Employee benefits administrator for assistance with your plan options or how your plan works with Medicare.

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MSP Disabled Under 65 with Employer Coverage- More than 100 Employees

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Pays First

Group Health Plan

Pays Second

Medicare

If you are **under age 65** and have Medicare because of a disability and also have group health coverage from your employer, or from your spouse's employer, Medicare pays **second** on your claims. Large group health plans always pay before Medicare, even if you are disabled.

****CSR NOTE:**

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.

• For help in filling out MSP development letters or questionnaires. • Report changes in employer size. • To report retirement or termination of disability insurance.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.

Associated Script

- **MP MSP Supplemental Crossover of Claims** to answer general questions about the crossover of claims to supplemental insurers.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

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MSP COBRA

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Pays First

Medicare

Pays Second

COBRA

COBRA is a law that allows you to keep your employer group health plan coverage for a limited period of time after your employment ends. This coverage includes all dependents who were covered under

the cancelled policy.

This is called **continuation coverage** and applies only to those employers with **20 or more employees**. If you are 65 or over OR disabled and covered by Medicare and COBRA, Medicare is the primary payer on your claims.

COBRA and Special Enrollment Period:
Even if you get COBRA coverage when your employment ends, you should still consider enrolling in Medicare Part B at the same time because you won't get another Special Enrollment Period.

The Special Enrollment Period means you will have to sign up for Medicare Part B within eight months after you lose your group health plan coverage or you will have to pay a higher Part B premium if you enroll at a later time.

COBRA and Employer Requirements:
If you are age 65 or older and you are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before your employment ends or before you lose your employer's coverage.

If you wait to sign up for Medicare Part B during the eight months after your employment or coverage ends, you may have to pay for your services during the time that you were without coverage. Signing up for Part B before your employer coverage ends will ensure that you don't miss a day of coverage.

Before you elect COBRA
Before you elect COBRA coverage, it may be helpful to talk with the State Health Insurance Assistance Program (SHIP) about whether buying a Medigap policy would be better for you than electing COBRA coverage.

COBRA and Medicare
If you have COBRA coverage when you first enroll in Medicare, your COBRA coverage may end. Your employer has the option of canceling your COBRA coverage if you enrolled in Medicare after the date you elected COBRA coverage.

****CSR NOTE:**

For changes to the primary insurance resulting from retirement, returning to work, or termination of the primary insurance: CLICK HERE

To report insurance that would pay secondary to Medicare: CLICK HERE

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.
• To report COBRA coverage. • MSP Secondary Claim development questionnaires or letters.	• Answer questions about Medicare claim or service denials and adjustments. • Answer questions about how to file a claim when there is more than one insurer. • Answer specific questions about the crossover of claims to supplemental insurers (how an actual claim is crossed over). • Answer questions about making a refund to Medicare due to a duplicate payment.
Associated Script • "**CS ESRD Basic Information**" click on “Coordination of Benefits” for more information on ESRD and coordination of benefits.	

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

REFERRAL =

- State Insurance Department.
- State Health Insurance Assistance Program (SHIP) for counseling. SHIP provides a broad range of services, including counseling on Medicare private plan options, Medicare appeals, COB, and low

MSP Liability No-fault Accident Insurance

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Pays First

76 of 97 No-fault or liability insurance

No-fault or Liability insurance pays first for services related to an accident claim. However, Medicare may make a **conditional payment** and pay as primary. When a settlement is reached, Medicare will recover the conditional payment from your settlement.

Pays Second

Medicare

Medicare is the secondary payer when **no-fault, liability insurance or workers' compensation** is available as the primary payer.

No-fault insurance pays for health care services that result from an injury to you regardless of who is at fault for causing the accident. Types of no-fault insurance include:

- Auto
- Homeowners
- Commercial insurance plans

Liability insurance is coverage that protects against claims for negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but is not limited to:

- Homeowners
- Auto
- Product
- Malpractice
- Uninsured Motorist
- Underinsured motorist liability insurance

Conditional Payments: If you receive services related to a no-fault, liability or workers' compensation insurance case, your doctor or other healthcare providers must try to get payments from the insurance company before billing Medicare. However, if your no-fault, liability or workers' comp plan denies your claim or does not pay your bills within **120 days** after your first claim is filed; Medicare may make a conditional payment.

A **conditional payment** is a payment that Medicare makes for services another payer is responsible to pay. This conditional payment is made so that you won't have to use your own money to pay the bill. This payment is "conditional" because it must be repaid to Medicare when a

settlement, judgment or award is reached. When a settlement is reached, Medicare will recover the conditional payment from your settlement. You are responsible for making sure that Medicare gets repaid for the conditional payment.

Refer to Coordination of Benefits Contractor	****CSR NOTE: Transfer to the appropriate Tier I Claims CSR.**	**Refer to MSPRC**
• Report a new liability, auto/no-fault case. • Questions about how Medicare works with your no-fault, liability insurance coverage. • MSP Secondary Claim development questionnaires or letters. • To determine the lead Medicare contractor handling specifics of the case (i.e., not previously reported to Medicare or to the Coordination of Benefits Contractor)	• Answer questions about Medicare claim or service denials and adjustments.	• For conditional payment amounts related to no fault, liability or workers' compensation insurance. • For Medicare's final recovery claim amount (settlement amount) or for questions about MSP recovery demand letters, see script **"CS MSP Demand and Recovery Letters"** to ensure proper referral to MSPRC or the appropriate Medicare contractor. • Questions about repaying monies to Medicare (cases already reported to Coordination of Benefits Contractor). If the case has not been reported to the MSPRC the caller will need to contact the Coordination of Benefits Contractor. • To update or close a liability case. • About appeal requests from beneficiaries on beneficiary MSP debt.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls". The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

TIP =

- Conditional payments are often confused with liens. Medicare does not place **liens** on people with Medicare.
- The MSP Recovery Contractor is available from 8 a.m. to 8 p.m. ET, Monday through Friday. The number is 866-677-7220.

WEB = Your Guide to Who Pays First - #02179

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MP MSP Workers' Compensation

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Pays First

Workers’ Compensation

Pays Second

Medicare usually doesn’t apply. However, Medicare may make a conditional payment.

Workers' compensation is insurance that employers are required to have to cover employees who get sick or injured on the job. If you do not know whether you are covered, ask your employer. If you think you have a work-related illness or injury, you must tell your employer to file a claim.

Conditional Payments: If you receive services related to a no-fault, liability or workers' compensation insurance case, your doctor or other healthcare providers must try to get payments from the insurance company before billing Medicare. However, if your workers' comp plan denies your claim or does not pay your bills within 120 days after your first claim is filed; Medicare may make a conditional payment.

A **conditional payment** is a payment that Medicare makes for services that another payer is responsible to pay. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment or award is reached. When a settlement is reached, Medicare will recover the conditional payment from your settlement. You are responsible for making sure that Medicare gets repaid for the conditional payment.

Refer to Coordination of Benefits Contractor	**CSR NOTE: Transfer to the appropriate Tier I Claims CSR.	Refer to MSPRC
• Report a new workers' compensation case. • Questions about how Medicare works with your workers' compensation insurance coverage. • To determine the lead Medicare contractor handling specifics of the case (i.e., not previously reported to Medicare or to Coordination of Benefits Contractor). • MSP Secondary Claim development questionnaires or letters. • To report a Workers' Compensation Medicare set-aside record or agreement.	• Answer questions about Medicare claim or service denials and adjustments.	• For conditional payment amounts related to workers' compensation. • For Medicare's final recovery claim amount (settlement amount) or for questions about MSP recovery demand letters, see script **"CS MSP Demand and Recovery Letters"** to ensure proper referral to MSPRC or the appropriate Medicare contractor. • Questions about repaying monies to Medicare (cases already reported to Coordination of Benefits Contractor). If the case has not been sent to the MSPRC the caller will need to contact the Coordination of Benefits Contractor. • To update a workers' compensation case or report the termination or settlement on a case. • About appeal requests from beneficiaries on beneficiary MSP debt.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

TIP = A Workers' Compensation Medicare set-aside arrangement saves a portion of the Workers' Compensation settlement for future medical expenses.

TIP =

- Conditional payments are often confused with liens. Medicare does not place **liens** on people with Medicare.
- The MSP Recovery Contractor is available from 8 a.m. to 8 p.m. ET, Monday through Friday. The number is 866-677-7220.

REFERRAL =

- The caller can contact the State Workers' Compensation Agency for workers' compensation denial. The beneficiary's employer can provide the phone number and address.

WEB = Your Guide to Who Pays First - #02179

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Medicare & Veterans Affairs (VA) Health Coordination

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The Department of Veterans Affairs (VA) provides health care benefits to veterans. The VA covers a number of health care services, including preventative services, diagnostic tests, and hospital stays. It may also cover nursing home and other long-term care options.
If you have both Medicare and Veterans benefits, you may be eligible to get health care services under either program. However, you'll have to make a choice. Claims cannot be paid by both programs for the same dates and services.

If you elect to have your claims submitted to Medicare, you will have to pay any deductible or coinsurance charged. However, any Medigap or supplemental policy you have may cover some or all of these charges.

If you are unsure about whether the VA or Medicare should pay, I can transfer you to a claims customer service representative who can help you further. Would you like me to transfer you?

ADDITIONAL INFORMATION:
VA claims might require a copayment for some services. You should call the Department of Veterans Affairs for more information.

To get services under the VA, you must go to a VA facility or have the VA authorize services in a non-VA facility. If the VA authorizes services in a non-VA hospital but doesn't pay for all of the services you get during your hospital stay, then Medicare may pay for the Medicare-covered part of the services that the VA does not pay.

CSR TIPS

SCRIPT = "Drug Coverage and Other Coverage" for information on how the VA works with the Medicare Drug plans.

SCRIPT = **Medicare & TRICARE for Life Coordination**

REFERRAL = Department of Veterans Affairs

WEB = www.va.gov

WEB = Your Guide to Who Pays First - #02179.

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Medicare & TRICARE for Life Coordination

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Pays First Medicare

Pays Second

TRICARE for Life

TRICARE for Life is medical coverage for Medicare-eligible uniformed services retirees age 65 or older, his or her eligible family members and survivors, and certain former spouses.

TRICARE acts as a secondary payer to Medicare. This means that if you have Medicare Part A and Part B, Medicare will consider payment on your claim first.

If the service is approved, Medicare will make payment to your doctor, hospital or supplier and will automatically send your claim to TRICARE.

TRICARE will send payment of the remaining approved amount to your provider of services. This would include any Medicare out-of-pocket expenses such as deductibles and coinsurance amounts.

TRICARE benefits not covered by Medicare:
If the service is not covered by Medicare but is a TRICARE benefit, (such as overseas travel or pharmacy) TRICARE will pay and you will be responsible for an annual deductible and cost share.

Medicare Services not covered by TRICARE:
If the service is covered by Medicare but not a TRICARE benefit (such as some chiropractic services), Medicare will pay as usual but TRICARE will not pay. You will be responsible for the Medicare deductible and cost share.

Services not covered by Medicare and not covered by TRICARE:
If the service is not covered by Medicare nor TRICARE (such as long-term or custodial care), you would be responsible for the costs. It is your decision to keep or buy a Medigap policy. If you have other insurance and drop it, keep in mind you may not be able to get it back or get a refund of your annual premium if you change your mind. If you choose to drop your Medigap or other coverage, the best time to do so would be **after** you are entitled to TRICARE for Life.

CSR TIPS

TIP = TRICARE beneficiaries over age 65 that are not eligible for Medicare and continue to be covered by TRICARE Standard may enroll in **TRICARE Prime**.

REFERRAL =

- DEERS Support Office at the Department of Defense for updating information
- TRICARE for Life Hotline 1-866-773-0404

SCRIPT =

- **MP Veteran's Health Coverage- (VA)**
- **MP MSP Supplemental Crossover of Claims**
- "Drug Coverage and Other Coverage" for information on how TRICARE works with the Medicare Drug plans.

MSP Federal Black Lung Program

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Pays First

Federal Black Lung Program, for black lung related services

Pays Second

Medicare, for all other healthcare services not related to black lung

Healthcare related to black lung disease is covered under workers' compensation. Medicare will not

pay for doctor or hospital services that are covered under the Federal Black Lung Program. For all other health care services that are not related to black lung, your bills should be sent directly to Medicare. Your doctor or other provider should send all bills for the diagnosis or treatment of black lung to the following address:

Federal Black Lung Program
P. O. Box 828
Lanham-Seabrook, MD 20703-0828

If the Federal Black Lung Program has denied your claim, your doctor or other provider should send Medicare a copy of the letter from the Federal Black Lung Program that says the reason they will not pay your claim.

Refer to the Coordination of Benefits Contractor
• For an explanation of how Medicare works with the Black Lung program. • To report a new case or a change in Black Lung information.

CSR TIPS

REFERRAL = Federal Black Lung Program for information about the Federal Black Lung Program at 1-800-638-7072.

SCRIPT = **MP MSP Workers Compensation** for more information about workers' compensation.

END

MP MSP Retired Federal Employees

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You need to call the Office of Personnel Management with questions about your federal retirement coverage and how it works with Medicare. You will need to call the Social Security Administration if you want your Medicare premium taken out of your monthly Federal annuity check.

CSR TIPS

REFERRAL = Office of Personnel Management (OPM)

REFERRAL = SSA - For general Medicare enrollment questions.

WEB = www.opm.gov for more information

SCRIPT = "Drug Coverage and Other Coverage" for information on how federal retirement coverage works with the Medicare Drug plans.

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Tier I Part B Claims CSR Transfer Language

****CSR NOTE: Making Appropriate Transfers to Tier I Part B Claims CSR**

I am going to transfer you to a claims representative who will assist you further.

- Gen Med CSRs should transfer calls directly to a **Tier I Part B Claims CSR** using the English **TNT Code 03** for **MSP issues only**.
- Use the Language Line for calls requiring Spanish translation.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

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COBC IVR

I can help you navigate quickly through COB's IVR. When the person first speaks, press 1 for English or 2 for Spanish. In the prompt that follows press 2 if you are a Medicare beneficiary and have a COB question. Follow the IVR prompts to complete your call.

TIP BOX:

REFERENCE MATERIAL = Medicare Coordination of Benefits Contractor IVR

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MP COB Record Update Timeframe

It takes a total of 15 business days for your information to be updated.

ASK: When did you submit your updated information?

> **If it has NOT been 15 business days, READ:** Since it hasn't been 15 business days, please call us back and we will be happy to go over the information with you.
>
> **If it has been OVER 15 business days:** Refer caller to the Coordination of Benefits Contractor (COBC).

CLICK HERE to assist beneficiaries with navigating the COBC IVR.

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Error Message Table

****CSR NOTE:** Use the table below to locate the Error Message and the Action to perform:

Error Message	Action
Must pass a location for update. Must pass a reason code for update	This error message means that you did not query using both HICN & the local Part B contractor ID. You will need to re-query with HICN & local Part B contractor ID and repeat the simple termination steps.

720 NO INSURER/VAL IND = Y	When you receive this error message, you will need to refer the caller to the COBC. You will not be able to update his or her MSP.
715 MSP END DATE INVALID	This error occurs when you try to enter a termination date that is equal to or earlier than the effective date of the MSP. If the caller indicates that he or she never had this MSP, you need to refer the caller to the COBC to delete the MSP. You can perform a simple termination only when the caller actually had a valid MSP instance and needs to terminate it (so the termination date will be after the effective date).
"0101: Can't convert formatted string to its internal representation. Please check if your data is in correct format."	The termination date must be entered in a MM/DD/YY (or YYYY) format. If you enter a date in any other format (e.g., month & year only – e.g., 02/02), you will receive this error message. You should re-enter the date in the correct format and try again.
005 INVALID DETAIL ACTION	This error code will appear if you enter the termination date in the form applet. If you enter the termination date in the list applet and then click the Update Termination Date button, NGD will automatically set the action code to C. If instead you entered the termination date in the form applet, you would need to use the drop down box in the form applet to set the action code to C. The preferred update method is to use the list applet.

****CSR NOTE:** If you are still unsuccessful in performing the simple termination for the calls that you did not refer to the COBC, proceed below:

- ****TIER I CLAIMS CSR**: Escalate to the appropriate PART B/MAC contractor as a complex inquiry using the Escalation Type field located on the Contacts, Beneficiaries, or Activities screen.
- ****TIER II CLAIMS CSR**: Escalate to the appropriate PART B/MAC contractor as a complex inquiry using the Escalation Type field located on the Contacts, Beneficiaries, or Activities screen.
- Enter the information into the Feedback tool under category General Medicare/Government Comments. Your

feedback submission must include the:

- Medicare Number
- Part B contractor ID used to query
- Complete detail error message
- Termination date you are trying to use

****CSR NOTE:** If you have never been able to perform a Simple Termination, inform your supervisor and onsite LSA immediately.**

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Paying Deductibles when Medicare is Secondary

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When Medicare is the secondary insurance, Medicare does not pay the deductible for the primary insurance. If Medicare's allowable amount is the same as the primary insurance's allowable amount, Medicare would not pay as secondary.

In some situations, you may be responsible for meeting the deductible for both the primary insurer and Medicare.

****CSR NOTE: Transfer to Tier I and Tier II Claims CSR for more detailed information.**

****CLAIMS CSR NOTE: Transfer to Tier II Claims CSR for complex issues.**

- Answer questions about how to file a claim when there is more than one insurer.
- Answer questions about how and how much Medicare pays as secondary on a specific claim.

CSR TIPS

TIP = For after hours transfer to Tier I and Tier II Claims CSR, see **SCRIPT** "CS After Hours Claims Calls." The Claims CSRs' hours of operation are 8 a. m. to 5 p.m. ET Monday through Friday.

Plan Complaints

Use this script if a beneficiary, pharmacist or anyone on behalf of a beneficiary has a complaint related to Medicare drug plans or Medicare Advantage Prescription Drug Plans. This script can also be used by Help Queue for EEs (both drug plans and MA Plans).

**If the caller wants to join, switch or disenroll from a plan, READ Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage.

**If the caller was denied enrollment into a drug plan, READ: RP Drug Coverage Denial Claim Enrollment Appeal.

If the caller is requesting a retroactive change to his or her 2006 enrollment (Enrollment Reconciliation) or the caller is no longer in the plan that he or she thought he or she had been in since 2006, READ: Plan Enrollment Reconciliation.

Keep in mind that you have to be in a valid election period to join another plan or to disenroll.

What is the problem?

- You have a problem with your plan and you want to stay enrolled in that plan.
- You are in the plan that you want, but you are still having problems with a previous plan.
- You were enrolled into a plan that you don't want and you want to switch plans.
- You are having problems disenrolling and you don't want to be in any plan.
- You want to know the status of your retroactive change request. (For a plan enrollment reconciliation and/or marketing misrepresentation.)

****The following links are for Help Queue ONLY.****

- Filing an Enrollment Exception (EE).
- Transfer due to the script "**Plan Enrollment Reconciliation**."

- Transfer for the reason "You were **misled** into joining a Medicare Advantage Plan (with or without drug coverage) when you thought you were joining a different type of plan."

- Transfer due to a **plan not participating in online enrollment** through the CSR Plan Finder Tool (**no "Enroll Now" button**).

- Transfer for the reason that the plan fails to have a **"best available evidence" (BAE)** process in place or will not honor acceptable evidence supplied.

Do you have the Contract number for your plan? The Contract number is necessary because it will allow your complaint to be addressed by the correct plan and be resolved in a timely manner. The Contract number is a letter followed by four numbers and then three additional numbers. If you have the letter and all seven numbers, please read them to me. If you have the letter and the first four numbers, please read them to me.

You may be able to find the contract number:

- On your plan's membership ID card. The Contract number is found in the bottom right of the card. [REFERENCE MATERIAL = Model Drug Coverage Member Identification Card, and Model MA PDP Member Identification Card]
- On letters you have received from your plan. The Contract number is found in the bottom left of the letter.
- On your Explanation of Benefits (EOB) from your plan.

****CSR NOTE:** If the caller is unable to find the Contract number, use the MA PDP tab to find the Contract number.**

Once you have the Contract number, click here to CONTINUE.

Do you have the Contract number for the plan that you are having a problem with? The Contract number is necessary because it will allow your complaint to be addressed by the correct plan and be resolved in a timely manner. The Contract number is a letter followed by four numbers and then three additional numbers. If you have the letter and all seven numbers, please read them to me. If you have the letter and the first four numbers, please read them to me.

You may be able to find the contract number:

- On the plan's membership ID card. The Contract number is found in the bottom right of the card. [REFERENCE MATERIAL = Model Drug Coverage Member Identification Card, and Model MA PDP Member Identification Card]
- On letters you may have received from the plan. The Contract number is found in the bottom left of the letter.
- On an Explanation of Benefits (EOB) from the plan.

****CSR NOTE:** If the caller is unable to find the Contract number, use the MA PDP tab to find the Contract number.**

Once you have the Contract number, click here to CONTINUE.

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Do you have the Contract number for the plan that you want to be enrolled in? The Contract number is necessary because it will allow your complaint to be addressed by the correct plan and be resolved in a timely manner. The Contract number is a letter followed by four numbers and then three additional numbers. If you have the letter and all seven numbers, please read them to me. If you have the letter and the first four numbers, please read them to me.

You may be able to find the contract number:

- On the plan's membership ID card. The Contract number is found in the bottom right of the card. [REFERENCE MATERIAL = Model Drug Coverage Member Identification Card, and Model MA PDP Member Identification Card]
- On letters you may have received from the plan. The Contract number is found in the bottom left of the letter.
- On an Explanation of Benefits (EOB) from the plan.

****CSR NOTE:** If the caller is unable to find the Contract number, use the MA PDP tab to find the Contract number.**

Once you have the Contract number, click here to CONTINUE.

(Top)

Do you have the Contract number for the plan that you are having a problem disenrolling from? The Contract number is necessary because it will allow your complaint to be addressed by the correct plan and be resolved in a timely manner. The Contract number is a letter followed by four numbers and then three additional numbers. If you have the letter and all seven numbers, please read them to me. If you have the letter and the first four numbers, please read them to me.

You may be able to find the contract number:

- On the plan's membership ID card. The Contract number is found in the bottom right of the card. [REFERENCE MATERIAL = Model Drug Coverage Member Identification Card, and Model MA PDP Member Identification Card]
- On letters you may have received from the plan. The Contract number is found in the bottom left of the letter.
- On an Explanation of Benefits (EOB) from the plan.

****CSR NOTE:** If the caller is unable to find the Contract number, use the MA PDP tab to find the Contract number.**

Once you have the Contract number, click here to CONTINUE.

(Top)

READ: Have you tried to contact your plan about this issue?

YES, but issue was not resolved.

YES, could not get through.

NO

What is the caller's complaint?

LIS issue (includes paying too much for drug copay, deductible, etc.)

LIS premium issue (paying too much)

Does not have ID card or confirmation letter

Not in plan they want (enrollment or disenrollment issue)

Formulary issue (drug not covered, drug price not correct (non-LIS), quantity limits or prior

approval)

Pharmacy will not accept ID card or letter

Premium withholding problem

Other

Is the complaint related to Fraud, Waste, or Abuse?

YES / NO

(CSR NOTE: Ask any of the following probing questions if needed and click on the appropriate link above.)

Did someone call you and try to enroll you into a drug plan over the telephone?

Are you listed on the National "Do Not Call" Registry and a plan called you even though you are on this registry?

Did you get an email that you did not request from someone claiming to be from Medicare or SSA about the Medicare drug coverage that asked for personal information?

Did someone come to your home uninvited, claiming to be from Medicare or SSA?

Did a plan ask about your personal health history when you tried to enroll in a plan?

Did a plan ask for payments when you enrolled over the Internet?

Did a plan send you materials without the "Medicare-Approved" seal?

Did someone ask you to sell your prescription drugs to another person?

Did someone ask you to sell your ID card to another individual?

Did someone ask you to have a prescription filled for them using your ID card?

Do you feel that your plan has discriminated against you in some way?

Are there prescriptions on your Explanation of Benefits (EOB) that you didn't receive?

Did you receive misleading or false information from a broker or marketing representative? CLICK HERE

Is your plan incorrectly calculating the amount that you spent out-of-pocket on drug costs? For example, you spent $1500 out-of-pocket and the plan tells you that you only spent $1200.

Is your plan encouraging you to disenroll when disenrollment is not required?

Did a pharmacist change the amount that you were supposed to pay out-of-pocket to help you get through the coverage gap?

Did the pharmacist illegally substitute a drug that your doctor said couldn't be substituted?

Please refer the caller to the MEDIC contractor.
READ: You will need to report this complaint to the Medicare Integrity Contractor who handles Medicare drug coverage complaints. They are handling all issues related to potential fraud, waste and abuse in the Medicare Prescription Drug program. You can call them at 877-7SAFERX or (877) 772-3379.

I also need to get some information from you.

****Enter the caller's information into the CSR feedback tool under the functional area of "AEP Issues".**

Please enter the following information:

- Broker's name and company

- Beneficiary's name
- Location of incident
- Date of call to 1-800-Medicare
- Plan name, if applicable. **For example**, if the broker is selling a particular plan.
- The incorrect or misleading information. **For example**, if the broker was marketing a Medicare Advantage Prescription Drug Plan and misleading the beneficiary to think it was a Medigap policy.

TIP = A broker is an independent agent who markets health plans or health systems.

(End of script)

Is the complaint related to Education and Outreach? (Use only if the caller is frustrated and does not want you to provide them with any other help.)

YES / NO

(CSR NOTE: Ask any of the following probing questions if needed and click on the appropriate link above.)

Do you need personalized help with your drug coverage choices?

Do you feel that you are not receiving enough help with your prescription drug coverage choices?

Do you need help filling out forms to enroll in a plan?

Do you need help understanding all of the materials you have received in the mail?

Do you need help filing an appeal or requesting an exception?

Is the complaint related to Quality of Care?

YES / NO

(CSR NOTE: Ask any of the following probing questions if needed and click on the appropriate link above.)

Did a pharmacy refuse to fill a prescription for you?
****CSR NOTE**: If the pharmacist can't fill a prescription because they are unable to verify drug plan enrollment or copay levels, the complaint is not related to the category Quality of Care. Please click here.

Did a pharmacy give you the wrong prescription?

Did a pharmacy give you the wrong dosage?

Did a pharmacy give you a partial prescription (example: should be a 30-day supply but only received a 20-day supply)?

Did a pharmacy refuse to help you understand the medication that you were prescribed?

Did your doctor prescribe a drug that caused a bad reaction?

READ: You will need to report this complaint to the Medicare Integrity Contractor who handles Medicare drug coverage complaints. They are handling all issues related to potential fraud, waste and abuse in the Medicare Prescription Drug program. You can call them at 877-7SAFERX or (877) 772-3379.

(End of script)

Refer the caller to State Health Insurance Assistance Program (SHIP) for counseling.

(**Note:** Please make sure you have helped the caller with all of their Medicare questions before referring them to the SHIP.)

Have you spoken to your doctor or pharmacist about this issue?

YES / NO

Refer the caller to their doctor or pharmacist.

READ: You should first talk to your doctor or pharmacist. If you talk to them and still do not feel like your problem has been resolved, you should call us back.

(End of script)

TNT to the Quality Improvement Organization (QIO) in the state where the care was given.

READ: I will need to transfer you to the Quality Improvement Organization (QIO) in your state. They will review your complaint(s) about the quality of care that you received. If you get an answering machine or service, please leave a message. Someone will return your call by the close of the next business day.

(End of script)

Go to MA PDP tab and check LIS subsidy level.

READ: Our records show that you should pay [insert LIS amounts] for your prescriptions. Is this the amount you are being charged?

YES

NO

This is the amount of extra help you have been approved for. Do you have documentation showing a different approval level?

YES / NO

Since you do not have documentation showing a different approval level, this is the amount you will continue to pay for your drugs.

What type of documentation do you have?

- Approval Letter from SSA (Escalate to the Reference Center, end of script.)
- Letter from CMS (Escalate to the Reference Center, end of script.)
- Letter from State Medicaid office (Click here.)

Go to MA PDP tab and check LIS subsidy level.

If LIS subsidy level is 100%, READ:
You should not be paying a premium UNLESS your plan's premium is higher than the average premium for a plan in your region. Please contact your plan for specific information about how much the premium should be.

If LIS subsidy level is anything BUT 100%, READ:
If you qualify for the extra help, you will pay a reduced premium based on the percentage listed in your award letter. Please contact your plan for specific information about how much the premium should be.

If the caller refuses to contact plan or has tried unsuccessfully to resolve the issue with the plan, click here to file a complaint.

(End of script)

Verify the caller's plan name from the MA PD Tab or the CSR Plan Finder Tool.

If plan is correct, click here. If the caller thinks that they are in a different plan than what is shown, READ:

The quickest way to fix this problem is to call your plan directly. The plan representatives can enter a temporary code in their system to enable you to get your drugs with the extra help. CSR NOTE: If the caller refuses to contact plan or was unsuccessful after contacting plan, click here.

Verify the caller's plan name from the MA PDP Tab or the CSR Plan Finder Tool.

If plan is correct, click here. If the caller thinks that they are in a different plan than what is shown, READ:
The quickest way to fix this problem is to call your plan directly. CSR NOTE: If the caller refuses to contact plan or was unsuccessful after contacting plan, click here.

You should only use this section if you already used the Premium Refund Issue Lookup in the Surveys tab and it directed you to file a complaint.

CLICK HERE if you already used the Premium Refund Issue Lookup

---

Check the CSR Plan Finder Tool. Are the drugs that the caller is taking on the formulary and is the caller using a network pharmacy?

If YES, READ: I can help you file a complaint. (Click here to file a complaint.)

If NO, READ: If you purchase a drug that is not on your plan's formulary or go to an out of network pharmacy, your copay will be higher. (End of script)

Go to script, Drug Coverage Enrollment Plan Unknown.

****If you already used the script and it directed you to file a complaint:****
Since you contacted your plan about this issue and they were unable to help you, I can file a complaint for you. Click here.

(End of script)

Verify the caller's plan enrollment/disenrollment status in the MA PD Tab or in the CSR Plan Finder Tool.

CSR NOTE: If the caller agrees with what is in the system, provide the plan phone number if necessary.

If system is not showing the correct enrollment status, offer plan name/phone number so the caller can follow up. If the caller refuses to contact plan or has tried unsuccessfully to resolve the issue with the plan, click here to file a complaint.

If the system is not showing a disenrollment:

1. Verify that the caller does intend to disenroll versus enroll in a different plan.
2. Ask the caller how they disenrolled previously (called plan or 1-800-Medicare).
3. Ask when they previously disenrolled.

If the prior disenrollment action was done more than 30 days ago, and the system still shows the enrollment in that plan, transfer to Tier 2 for disenrollment. (End of script)

Go to the CSR Plan Finder Tool and enter the confirmation number or the caller's drugs.

Find the caller's plan and use the drop-down box to "view drug details." Review plan information with the caller such as:

- whether the drug is on the formulary list
- any quantity limits
- step therapy
- prior authorization
- drug costs at each phase of the benefit

If issue is resolved, end of script.

If issue is not resolved, provide the caller with the plan's name/phone number for further discussion with plan. If the caller refuses to contact plan or has tried unsuccessfully to resolve the issue with the plan, click here to file a complaint.

Refer the caller to their prescription drug plan.

READ: The fastest way to get an issue resolved is to contact your plan. If you have not tried within the past week, you should try to contact the plan again. Many plans now have little or no wait times. It might help if you try at different times of the day. If you talk to them and still do not feel like your problem has been resolved, you should call us back. Remember that if you need to call us back again, you will need the Contract number.

Note: If the caller refuses to contact plan or has tried unsuccessfully to resolve the issue with the plan, click here.

Note: If the caller does not know their plan's phone number, they should be able to locate it on their drug plan card or a recent statement received from their plan.

(End of script.)

EEs - Help Queue only

****This section is only to be used for regular EEs. If the call is about a plan reconciliation or a caller being given misleading information, go back to the top and click on the corresponding hyperlink.****

****CSR NOTE**: When entering an EE, **use the Help Queue "Bypass" Code** and do not use or enter a Contract number.**

READ:
Your enrollment request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. They will decide if you can still enroll.

CSR NOTE: Do not enroll the caller in a drug plan or Medicare Advantage Plan.

****CSR NOTE: Click "Next" below to enter complaint.**

- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering an EE, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

Help Queue only: Plan Enrollment Reconciliation

****CSR NOTE: Use complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Reconciliation - Dissatisfied with Decision."**

READ:
Your enrollment request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. The CMS Regional Office will review your situation and, if appropriate, can update your records.

Please keep in mind that you will be responsible for any applicable premiums and cost-sharing (deductibles and copayments) back to the effective date of the change.

- **If this change returns you to a Medicare Advantage Plan**, you may also need to see that plan's network of providers. You should check to see if your providers are a part of that plan's network.
- **If this change involves Medicare drug coverage**, the new plan will also have its own network of pharmacies and a formulary. You should check to see if the drugs you use are included on that plan's formulary and if the pharmacies you use are in that plan's network.

Based on this information, would you still like me to send your request to the Centers for Medicare and Medicaid Services for review?

If NO, end the call.
If YES, continue with filing the EE.

If the CSR who transferred the call to you:	Copy and paste this language into the Issue/Complaint field:
Enrolled the beneficiary	ENROLLMENT RECONCILIATION SEP. Note that we enrolled the caller into [PLAN NAME AND CONTRACT NUMBER] effective [FIRST DAY OF NEXT MONTH]. The caller wants [FILL IN THE BLANK] to happen.
Did NOT enroll the beneficiary	ENROLLMENT RECONCILIATION SEP. The caller wants [FILL IN THE BLANK] to happen.

****CSR NOTE: Click "Next" below to enter complaint.**

- **Enter complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Reconciliation - Dissatisfied with Decision."**
- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering an EE, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

****If the caller asks how long it will take for the records to be updated after a retroactive change, CLICK HERE.****

Help Queue only: Misleading Information

Does the caller qualify for the SEP "You were **misled into joining a Medicare Advantage Plan** (with or without drug coverage) when you thought you were joining a different type of plan."?

- Caller **qualifies** for the SEP reason, CLICK HERE.
- Caller **does not** qualify for the SEP reason or you're not sure, CLICK HERE.

Help Queue only: Marketing Misrepresentation

****CSR NOTE: Use complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Exception - Marketing Misrepresentation."**

READ:
Your request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. The CMS Regional Office will review your situation and, if appropriate, can update your records.

Please keep in mind that you will be responsible for any applicable premiums and cost-sharing (deductibles and copayments) back to the effective date of the change.

- **If this change returns you to a Medicare Advantage Plan**, you may also need to see

that plan's network of providers. You should check to see if your providers are a part of that plan's network.
- **If this change involves Medicare drug coverage**, the new plan will also have its own network of pharmacies and a formulary. You should check to see if the drugs you use are included on that plan's formulary and if the pharmacies you use are in that plan's network.

Based on this information, would you still like me to send your request to the Centers for Medicare and Medicaid Services for review?

If NO, end the call.
If YES, continue with filing the EE.

If the CSR who transferred the call to you:	**Provide a detailed description of the caller's situation AND copy and paste this language into the Issue/Complaint field:**
Enrolled the beneficiary	1-800-MEDICARE MARKETING MISREPRESENTATION SEP. Note the caller was enrolled with [PLAN NAME AND CONTRACT NUMBER] and we enrolled the caller into [PLAN NAME AND CONTRACT NUMBER] effective [FIRST DAY OF NEXT MONTH]. The caller wants a retroactive effective date of [FILL IN THE RETRO DATE]. Caller was misled by [AGENT'S NAME].
Disenrolled the beneficiary (You should NOT use the option of MA-RD; follow the process outlined in this section.)	1-800-MEDICARE MARKETING MISREPRESENTATION SEP. Note that we disenrolled the beneficiary from [PLAN NAME AND CONTRACT NUMBER] effective [FIRST DAY OF NEXT MONTH]. The caller wants a retroactive effective date of [FILL IN THE RETRO DATE]. Caller was misled by [AGENT'S NAME].

****CSR NOTE: Click "Next" below to enter complaint.**

- **Enter complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Exception - Marketing Misrepresentation"**
- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering an EE, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

****If the caller asks how long it will take for the records to be updated after a retroactive change, CLICK HERE.****

Help Queue only: Marketing Misrepresentation Denial

****CSR NOTE: Use complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Exception - Marketing Misrepresentation."**

READ:
Your request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. The CMS Regional Office will review your situation and, if appropriate, can update your records. If the Regional Office decides that you're not eligible for the change at this time, then they will send you a written denial letter.

Provide a detailed description of the caller's situation AND copy and paste this language into the Issue/Complaint field:

1-800-MEDICARE DENIAL OF MARKETING MISREPRESENTATION SEP. The beneficiary is enrolled with [PLAN NAME AND CONTRACT NUMBER] and wants the following changes made [INSERT PROSPECTIVE AND RETROACTIVE REQUESTS]. Marketing Misrepresentation SEP was denied by 1-800-MEDICARE because [INSERT DESCRIPTION OF DENIAL REASON]. Caller was misled by [AGENT'S NAME].

****CSR NOTE: Click "Next" below to enter complaint.**

- **Enter complaint category "Enrollment/Disenrollment." Then choose complaint "Enrollment Exception - Marketing Misrepresentation"**
- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering an EE, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

****If the caller asks how long it will take for the records to be updated after a retroactive change, CLICK HERE.****

Help Queue only: Plan Not Participating in Online Enrollment

If the CSR who transferred the call was unable to enroll the beneficiary, READ:
The plan you want to enroll in is not participating in online enrollment. Because of this, your request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. The CMS Regional Office will review your request for enrollment into the plan and can update your records. If the Regional Office decides that you're not eligible for the change at this time, then they will send you a written denial letter.

****CSR NOTE: Use complaint category "Enrollment/Disenrollment." Then choose the appropriate complaint subcategory (either "Enrollment Reconciliation - Dissatisfied with Decision" or "Enrollment Exception - Marketing Misrepresentation").**

If the situation is about:	Copy and paste this language into the Issue/Complaint field:
Enrollment reconciliation	ENROLLMENT RECONCILIATION SEP. The plan that the beneficiary wants to enroll in is not participating in online enrollment. The caller wants to enroll in [PLAN NAME AND CONTRACT NUMBER].
Misleading marketing misrepresentation	1-800-MEDICARE MARKETING MISREPRESENTATION SEP. The plan that the beneficiary wants to enroll in is not participating in online enrollment. Caller is currently enrolled in [PLAN NAME AND CONTRACT NUMBER] but wants to be enrolled in [PLAN NAME AND CONTRACT NUMBER]. Caller was misled by [AGENT'S NAME]

****CSR NOTE: Click "Next" below to enter complaint.**

- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering an EE, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

Help Queue only: Plan doesn't accept Best Available Evidence

****CSR NOTE: Use complaint category "Plan Administration." Then choose complaint "Best Available Evidence (BAE) - Failure to Correct Low-Income Subsidy Status/Level."**

READ: Your request will be forwarded to the Centers for Medicare and Medicaid Services (CMS) Regional Office for your state. The CMS Regional Office will review your situation and will call you within the next 48 hours.

Provide a detailed description of the caller's situation AND copy and paste this language into the Issue/Complaint field:
BEST AVAILABLE EVIDENCE. The beneficiary is enrolled with [PLAN NAME AND CONTRACT NUMBER] and the plan or the pharmacy is not accepting [TYPE OF BAE PROVIDED] as "best available evidence" documentation.

****CSR NOTE: Click "Next" below to enter complaint.**

- **Enter complaint category "Plan Administration." Then choose complaint "Best Available Evidence (BAE) - Failure to Correct Low-Income Subsidy Status/ Level."**
- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**
- **When entering this complaint, use the Help Queue "Bypass" Code and do not use or enter a Contract number.**

Complete the PDP Plan Referral.

FOR COMPLAINTS, READ: I will need to get some information from you in order to log your complaint. When I am finished, your complaint will be forwarded to your plan for resolution. Someone from the plan will work to resolve your complaint as soon as possible. Please call the plan for more information or to see if the issue has been resolved.

TIER II ONLY - RETROACTIVE DISENROLLMENTS (RD) **CSR NOTE: If the caller is requesting a retroactive disenrollment because of an MA marketing misrepresentation issue, click here.** **Otherwise,**

> **READ:** I will need to get some information from you. When I am finished, your request for an adjustment to the disenrollment date will be forwarded to your plan for resolution. Someone from the plan will work to resolve the issue as soon as possible. Please call the plan for more information or to see if the issue has been resolved. Once your disenrollment information has been updated in our system, your provider should resubmit the claim to Medicare for processing.

CSR NOTE: If the caller asks how long it will take to resolve the complaint, READ:
Your issue is important to us and it will be given serious attention. Unfortunately, I am unable to give you a specific time frame. Please call the plan for more information or to see if the issue has been resolved.

If they already filed a complaint and it has been less than 48 hours for urgent complaints or less than 5 business days for non-urgent complaints, READ:
I see that you have already filed a complaint. It is being worked on and we appreciate your

patience. Please call the plan for more information or to see if the issue has been resolved.

If they already filed a complaint and it has been longer than 48 hours for urgent complaints or longer than 5 business days for non-urgent complaints, file another complaint.

****CSR NOTE: Click "Next" below to enter complaint.**

- **Be sure to enter the correct Contract number provided by the beneficiary. (It is case-sensitive.)**
- **Do not enter your personal commentary or your opinions in the complaint form.**
- **Do not enter the characters < > ; & ^ in the complaint form.**

Call the Help Queue.

****CSR NOTE: If the caller requests a retroactive change**, warm transfer to the Help Queue and explain that the caller qualifies for the MA marketing misrepresentation SEP and is requesting a retroactive change. The Help Queue will submit this as an **Enrollment Exception (EE)** by using the script in the PDP Plan Referral Survey.****

- If you submitted an enrollment, provide the plan name and contract number to the Help Queue.
- If you processed a disenrollment, explain to Help Queue all actions that were taken during the call, including any enrollments or disenrollments (including any actions taken by another CSR).
- The **Help Queue agent** needs to enter the "Bypass" Code and NOT the contract number into the Complaint Contract Number field. Help Queue should follow this script for additional instructions regarding this EE.

Retroactive change for a plan enrollment reconciliation and/or marketing misrepresentation.

If the caller asks how long it will take for the records to be updated after a retroactive

change for plan enrollment reconciliation or marketing misrepresentation, READ:
We've processed the change that you requested today (prospective change). It will be effective on the first day of the next month. However, it will take 3-4 weeks before your request for a retroactive change is processed. You may be contacted after the update has been made to your records. If you are not contacted, please feel free to call us back in 4 weeks. We can check your records to see if they have been updated.

CS MyMedicare.gov

Choose the appropriate link below for MyMedicare.gov:

MyMedicare.gov General and Personal Information	**MyMedicare.gov Enrollment and Enrollment Letter**
Change in Web address – e-MSN to MyMedicare.gov	**MyMedicare.gov Technical Issue**
MyMedicare.gov Enhancements	**MyMedicare.gov Claims Information**

****CSR NOTE:** If the caller wants to discuss personal information on MyMedicare.gov, he or she must pass disclosure.****

MyMedicare.gov General Information

MyMedicare.gov Personal Information

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MyMedicare.gov Enrollment Letter

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MyMedicare.gov - General Information

MyMedicare.gov is a tool on the **Medicare.gov** website. MyMedicare.gov is a free, secure site designed to help you check the status of your eligibility, enrollment, and other Medicare benefits. It also allows you to access your claims information almost immediately after it is processed by Medicare and provides you with preventive health information 24 hours a day, seven days a week. You can register on MyMedicare.gov so you can access your information at any time.

Using MyMedicare.gov allows you to:

- Receive important Medicare-related information.
- View Medicare claims status (excluding Medicare prescription drug claims).
- View eligibility, entitlement, and preventive service, and Medicare Secondary Payer (MSP) information.
- Order a replacement Medicare card or a duplicate Medicare Summary Notice (MSN).
- View or modify your prescription drug list or pharmacy information.
- View information on your personal health records (PHR).
- Access online forms, publications and messages sent to you by the Centers for Medicare and Medicaid Services (CMS).
- View your Medicare enrollment information, including a prescription drug plan.
- View address of record with Medicare and Part B deductible status

I can tell you how to register on MyMedicare.gov to view your claims information.

****IMPORTANT:** Please keep in mind these two claims hints:

1. There is a 4-6 week claim processing time.
2. Make sure when looking for claims information you are in the **My Claims** section of MyMedicare.gov.

****CSR NOTE**:

- To tell the caller how to enroll on MyMedicare.gov or to enroll the beneficiary, **CLICK HERE**.
- If the caller is experiencing problems with MyMedicare.gov, **CLICK HERE**.

CSR Tips:

TIP = Beneficiaries are able to read important messages specific to them under the **My Messages** tab.

TIP = Medicare beneficiaries who are new to Medicare receive a letter informing them that they were automatically registered to use the MyMedicare.gov website. This letter also contains a password. Beneficiaries who enroll on their own, asked a CSR to enroll them, or were registered by a representative also receive a letter with a password informing them they are enrolled in MyMedicare.gov.

TIP = Each Medicare Summary Notice is stored on MyMedicare.gov for 15 months for beneficiaries to view and order.

TIP = Replacement Medicare cards may take up to 30 business days to arrive.

TIP = If the beneficiary recently updated his or her address, it may take 7-14 business days to see this change reflected on MyMedicare.gov

TIP = A Personal Health Record (PHR) is a tool used to compile health information such as medications, allergies, hospitalizations, conditions, and doctor visits. A PHR is mainly composed of information provided by your doctor about your visit and submitted to your health plan for payment. Your PHR is kept secure by the same health plan that pays your claims.

SCRIPT= CS MSN Claims Transfer, if caller requests a copy of their MSN.

PUBLICATION = MyMedicare.gov (#11297)

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Change in Web address – e-MSN to MyMedicare.gov

Read if the caller has recently tried to access the website www.palmettogba.com/emsn to view a copy of his or her MSN:

You will notice that you were redirected to the website MyMedicare.gov. If you are or were a Palmetto e-MSN user, you have been automatically registered for access to MyMedicare.gov. Even though you were directed to a new website, you will still be able to access all the same information and more through MyMedicare.gov.

****CSR NOTE:** To instruct Palmetto e-MSN users on how to register for access to MyMedicare.gov,
READ: Please go to the login page at the top left-hand corner of the MyMedicare.gov homepage. You may then fill in your Medicare number as it appears on your Medicare card and password as it appears on your MyMedicare.gov password letter which you received in the mail or by email if you provided an email address during registration.

****CSR NOTE:** If the caller is asking about MyMedicare.gov and has **not** received a MyMedicare.gov enrollment letter,
READ: I can tell you how you can register on MyMedicare.gov to access your information.

****CSR NOTE:**

- To enroll the beneficiary on MyMedicare.gov **CLICK HERE**.
- If the caller wants general information about MyMedicare.gov, **CLICK HERE.**
- If the caller has problems with MyMedicare.gov (unable to access system, wrong/lost password, not able to navigate system, etc.), **CLICK HERE**.
- If the caller asks about specific claim or preventive service information, and it's after hours, please read script, CS After Hours Claims Calls.
- If the caller asks about a specific claim or a specific preventive service date during normal business hours, **READ**:

  I'm sorry, but I don't have access to your medical or claims records. I can transfer you to a claims representative who will be able to help you with specific questions about your individual health record and claims.

CSR Tips:

TIP = Use TNT code ***339** to transfer call to the MBP Technical Support team.

TIP = http://www.palmettogba.com/emsn is the old web site used for e-MSNs.

TIP = All states are now able to use the MyMedicare.gov for claims information.

TRANSFER = Claims CSR for questions about specific claims during normal business hours.

TIP = If the caller says that the enrollment status information on MyMedicare.gov is incorrect, **CLICK HERE**.

TIP = If the caller wants to discuss their personal information in MyMedicare.gov, he or she must pass disclosure.

PUBLICATION = MyMedicare.gov (#11297)

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MyMedicare.gov Enrollment

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Personal Information on MyMedicare.gov

CSR NOTE: If the caller wants to discuss their personal information on MyMedicare.gov, he or she must pass disclosure.**

CSR NOTE: If MyMedicare.gov shows that the beneficiary is in a different type of plan than he or she thinks (i.e. MA Plan instead of Original Medicare), check the MA PDP tab to get the plan type (PDP, MA, or MA-PD).

If NGD shows that the beneficiary is not in the type of plan that he or she wants, READ:
Our records show that you are in [PLAN] which is a [TYPE OF PLAN]. If you want to switch plans, you will have to wait for a valid enrollment period. If you have questions about your plan, please contact the plan for more information.

****CSR NOTE:** If the caller wants to go into details about the information on the MyMedicare.gov website, **CLICK HERE**.

****CSR NOTE:** If the beneficiary says that his or her information on MyMedicare.gov is incorrect, enter what information is incorrect in Feedback under the Medicare.gov functional area.**

CSR Tips:

SCRIPT = Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage, for information about PDP and MA enrollment periods.

TRANSFER = Claims CSR (during business hours) for questions about specific claims that cannot be answered using the BCC Tier I View.

TIP = If caller wants to discuss personal information in MyMedicare.gov, he or she must pass disclosure.

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MyMedicare.gov Technical Issue

****CSR NOTE**: If the caller is reporting missing or incorrect MyMedicare.gov Web Portal claims information, do **not** transfer to the Medicare Beneficiary Portal (MBP) Technical Support team. This is **not** a technical issue.

Please use NGD to assist the caller. If required, make the appropriate transfer to a Claims CSR.**

****CLAIMS CSRS ONLY**: If you are unable to locate the missing or incorrect MyMedicare.gov Web Portal claims information in NGD, please advise the caller to speak with his or her healthcare provider and have the claim(s) resubmitted.**

Click here for a list of recent technical issues.

****CSR NOTE**: If the caller has problems with MyMedicare.gov (unable to access system/view information, wrong/lost password, not able to navigate system, etc.) on MyMedicare.gov website, **READ**:
I'm sorry you are experiencing technical problems with MyMedicare.gov. You may click on the live chat session icon on the right side of your screen to open a live chat session over the Internet with one of our Technical Support Representatives. If you prefer to speak to someone by phone, I can transfer you to a Technical Support Representative who will be able to assist you, or you can call 1-877-607-9663 24 hours a day, seven days a week for technical issues. Which would you prefer?

****If the caller is having problems registering on the MyMedicare.gov site, READ:**
After entering your personal information when first registering for the tool, you might have received an error message stating the request could not be processed. It's important that you use the link provided and go back through the registration process and this time **do not** insert your email address. You will then be able to complete your registration and a password letter will be **mailed** to you. You can then enter your email address at a later time by going to the My Accounts tab on MyMedicare.gov.

****CSR NOTE**: Proceed with the caller's preference.

Once your problem is resolved, a follow-up message will be posted on the My Messages page. You can view these messages under the My Messages tab. Thank you for your patience.

CSR Tips:

TIP = Use **TNT code *339** to transfer call to the Medicare Beneficiary Portal (MBP) Technical Support team if the caller is experiencing technical issues that you cannot answer with scripting or if the caller is experiencing technical issues and cannot or does not wish to open a live chat session with one of our technical support representatives.

TIP = If the beneficiary is already a registered user and has trouble logging into the website, he or she can click on "trouble logging in" on the login page.

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MyMedicare.gov Enrollment

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****CSR NOTE:** To tell the caller how to enroll on MyMedicare.gov, **CLICK HERE**.

Enroll the caller (only if requested)

****CSR NOTE**: Register the caller on MyMedicare.gov only if he or she requests to be registered. **

If the caller requests to be enrolled on MyMedicare.gov, **CLICK HERE**.

****CSR NOTE**: If the caller has already registered and wonders why he or she has not received an enrollment letter with a password, **READ:**

It takes 10-14 business days after enrolling or being auto-enrolled on MyMedicare.gov to receive a letter containing your password. The letter will be sent to the address that the Social Security Administration (SSA) or Railroad Retirement Board (RRB) has on file for you. Please allow 10-14 business days to receive the letter. You may also provide your email address during registration to receive your password via email for immediate access to the site.

****CSR NOTE**: If it has been **more than** 14 business days and the caller has not received a letter, tell the caller how to reenroll on MyMedicare.gov. **CLICK HERE**.

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MyMedicare.gov Enrollment Letter

****CSR NOTE:** Read **ONLY** if the caller says that he or she received a letter stating he or she enrolled or was auto-enrolled in **MyMedicare.gov**.

CSR Tips:

PUBLICATION = MyMedicare.gov (#11297)

****CSR NOTE**: MyMedicare.gov auto-registration letters were recently sent with wrong password information. Rather than including the correct password, the auto-registration letters had the symbols *****. Included in the letter are the telephone numbers for the MBP technical line and 1-800-Medicare. If you receive a call from a beneficiary about this situation, please advise the beneficiary that he or she will soon receive a revised letter with the correct password information. Please **do not** advise the beneficiary to re-register on the portal. If the beneficiary's question is not about this situation, please proceed with the information below.

You may have recently received a letter indicating that you enrolled or were auto-enrolled in the MyMedicare.gov website. MyMedicare.gov provides all of your personal Medicare-related information in one place. This service allows you to:

- Receive important Medicare-related information.
- View Medicare claims data (excluding Medicare prescription drug claims).
- View eligibility, entitlement, and preventive service information.
- Order a replacement Medicare card or a Medicare Summary Notice (MSN).
- View or modify your prescription drug list or pharmacy information.
- View your Medicare enrollment information, including a prescription drug plan.

To log on to MyMedicare.gov and activate your information, follow the steps indicated in the letter you received.

****CSR NOTE: If the caller needs help with the instructions in the enrollment letter, ASK:** Do you have that letter with you now?

If **YES**, follow the steps below:

1. Go online to **http://MyMedicare.gov/** and login at the top left-hand corner of the MyMedicare.gov homepage.
2. Enter your Medicare number (as it appears on your Medicare card) and the password listed in your letter.
3. Select a Secret Question and Answer. This helps you if you ever forget your password or want to change it.
4. Click on the link to "Online Service and Web Confidentiality Agreement" and read the associated material. Once you have read the information, check the Online Service and Web Confidentiality Agreement checkbox.
5. Change your existing password.

To protect your personal Medicare information, please exit MyMedicare.gov by clicking on the Logout button at the top right-hand corner of the page. The Logout button can be found on every page within MyMedicare.gov.

You should now be registered for MyMedicare.gov. If you need more help, please use the Reference Guide for MyMedicare.gov instructional material that you received with your enrollment letter, or you can call 1-877-607-9663.

****CSR NOTE:** If the beneficiary or a representative calling on their behalf lost the letter, **READ**: If you lost the enrollment letter, you should re-register.

****CSR NOTE**:

- To instruct the beneficiary or a representative calling on their behalf on how to enroll on MyMedicare.gov,**CLICK HERE**.
- If the beneficiary or a representative calling on their behalf requests to be enrolled on MyMedicare.gov, **CLICK HERE**.

If the caller received the letter in error, READ:
If you received the letter in error (you are not new to Medicare; you were not an e-MSN user, you did not register, or you did not authorize someone to register you on MyMedicare.gov), please call toll free at: 1-877-607-9663.

CSR Tips:

- **TIP = Who receives the letter?** People who are new to Medicare, Palmetto e-MSN users, beneficiaries who enrolled, asked a CSR to enroll them, or were enrolled by a representative calling on his or her behalf are receiving the letter.
- **TIP** = If the caller forgot the shared secret question and answer for the **Forgot Password** link, he or she has three chances to try to enter it. This option can be used only if he or she has previously logged into the site successfully with the MyMedicare.gov enrollment letter. If he or she fails to answer the question correctly three times, he or she will be locked out of the system for 30 minutes and will have to re-register. He or she will receive a new letter with a new password.
- **TIP** = If the beneficiary wants to disenroll from the MyMedicare.gov site, please explain that no one can access his or her MyMedicare.gov account without the password he or she received. If the beneficiary insists on disabling his or her account, explain that destroying this password letter will disable access to MyMedicare.gov and access to the personalized healthcare-related information that is contained in the website.
- **TIP** = The MyMedicare.gov account becomes disabled after the beneficiary has been deceased for more than 180 days. Please refer these calls to a Claims CSR.
- **TIP** = If the beneficiary is already a registered user and has trouble logging into the website, he or she can click on "trouble logging in" on the login page.
- **TIP** = If the caller believes that he or she should have received an enrollment letter but hasn't (The "Enroll MyMedicare.gov" button will be grayed out), please ask probing questions to make sure the beneficiary has waited 14 business days after enrollment to receive the letter.
- **TIP** = If the caller requests a duplicate enrollment letter, tell the caller to re-register. A duplicate letter cannot be issued, but a new letter with a new password will be issued.
- **TIP** = There is a link for Railroad Retirement Board (RRB) beneficiaries on the Registration page.
- **TIP** = If a beneficiary has already registered and received a password letter in the mail, then the CSR/NGD "Enroll" button should appear grayed out and will not be functional. The CSR will not be able to enroll the beneficiary. The beneficiary will need to use the letter to login.
- **TIP** = " If the caller wants to discuss personal information in MyMedicare.gov, he or she must pass disclosure.

REFERENCE MATERIAL = MyMedicare.gov Sample Password Letters

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Tell the caller how to enroll in MyMedicare.gov

To register on MyMedicare.gov, follow the steps that I'm about to tell you:

- Go online to **http://MyMedicare.gov** and click on the Sign Up link on the welcome and login page.
- Follow the instructions. Upon successful registration, a letter containing your password will be mailed to you within 10-14 days confirming your enrollment in MyMedicare.gov. If you provide Medicare your email address, a temporary password will be sent to you by email. You will use that password to login and you will be prompted to change that password. You must register with the same address that the Social Security Administration (SSA)/Railroad Retirement Board (RRB) has on file for you. Even if you provide Medicare your email address, you will still receive a letter in the mail with your temporary password.

****If the caller received an error message while registering on the MyMedicare.gov site, READ:**
After entering your personal information when first registering for the tool, you might have received an error message. It's important that you go back through the registration process and this time **do not** insert your email address. You will then be able to complete your registration and a password letter will be **mailed** to you. You will not be able to get a password by email at this time. You will be able to enter your email address at a later time by going to the My Accounts tab on MyMedicare.gov.

CSR Tips:

TIP = If the caller wants to discuss his or her personal information in MyMedicare.gov, he or she must pass disclosure.

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Enroll the caller (only if requested) in MyMedicare.gov

__CSR NOTE:__ Register the caller on MyMedicare.gov **only if he or she requests to be registered.**

Before enrolling caller into MyMedicare.gov, he or she **must pass disclosure. If the caller is not able to pass disclosure, please ask him or her to call back when the necessary information is available. If disclosure was not passed and the caller asks for help with another issue, continue the call. If not, end the call per normal protocol.**

**After the caller has successfully passed disclosure, select the "Enroll MyMedicare.gov" button, and follow

instructions to enroll the beneficiary.**

CSR NOTE: If you are experiencing technical problems enrolling the beneficiary in MyMedicare.gov, please **READ:**
We are currently experiencing technical problems enrolling you in MyMedicare.gov. I'm sorry for the inconvenience. Please call us back later and we will be happy to enroll you.

CSR NOTE: Once registration is complete, **READ:**
You are now registered on MyMedicare.gov. A letter containing your password will be mailed to you within 10-14 business days. The letter will confirm your enrollment in MyMedicare.gov. The letter will be sent to the same address that the Social Security Administration (SSA)/Railroad Retirement Board (RRB) has on file for you/the person with Medicare.

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Recent MyMedicare.gov Technical Issues Requiring a Transfer to a Technical Support Representative

- The beneficiary is unable to save his or her drug list on the My Drugs tab.
- Re-registration Loop - The Forgot Password link says that he or she needs to first login. The attempt to re-register results in a message stating that he or she is already registered, without the option to select

a reason and continue with the re-registration. The beneficiary's password might be lost or not working.
- The beneficiary gets an error message after logging in and changing his or her password and is now allowed to view the home page.
- The beneficiary gets an error message stating that his or her request could not be processed.

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MyMedicare.gov Enhancements

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Deceased Beneficiary

If access to a beneficiary's account is attempted less than or equal to 180 days after a beneficiary's Date Of Death (DOD), then access will be granted. If more than 180 days have passed since the beneficiary's DOD, login attempts to the beneficiary account will result in the appropriate (and already existing) error message:

> "This account has been disabled and access to MyMedicare.gov is no longer allowed. Please call 1-800-MEDICARE, if you need additional assistance."

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MyMedicare.gov Entitlement Letter

As a MyMedicare.gov 1.9 release enhancement, a check box will be included in the address verification page displayed once the users click on the Order Replacement Medicare card link. The following text will be included with the check box:

> "By checking this box, you choose to receive an entitlement letter. You will receive this letter before you receive the replacement Medicare card. You may use this letter as proof of your Medicare entitlement, until you receive your new Medicare card."

This check box will be unchecked by default and this will be an optional field. The beneficiary will be allowed to continue ordering the replacement Medicare card without checking this check box. There will be a new order confirmation page displayed to the users/beneficiaries that choose not to receive an entitlement letter.

This new confirmation page will have the following text:

> "Your request for a replacement Medicare card is complete and is being verified with the system. Upon successful verification, your replacement Medicare card will be mailed to your address on file with the Social Security Administration (SSA) within 30 days."

The users/beneficiaries who choose to receive an entitlement letter will be navigated to the current replacement Medicare card order confirmation page.

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Medigap Help File Page

The user will access the Medigap Help File page by clicking on the Medigap link, located on the My Drug and Health Plans tab. The Medigap link will be located in the Other Insurance section on the My Drug and Health Plans tab. The text will appear as follows:

"For more information regarding Medigap Policy, please click here."

The Medigap help text will appear above the Other Insurance sections on the My Drug and Health Plans tab **only if** the following conditions apply:

1. User possesses Medigap insurance. This can be confirmed by seeing "Medigap" within the Insurer Name field, in Other Insurance section of the "My Drug and Health Plans"

2. Termination date for Medigap is Null or greater than or equal to the current date (in other words, the termination date for the user's Medigap has not yet passed and is current).

When the user clicks on the Click Here link in the comment relating to Medigap, the user will be directed to the following page: http://www.medicare.gov/medigap/default.asp, which provides details about Medigap.

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Reason for Re-registration Error Page

The new message for this section will now say:

"Our records indicate that the Medicare Number has already been registered. Please select a

reason if you would like to re-register on MyMedicare.gov and click the Continue button. To return to the Login page, click Cancel."

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MyMedicare.gov Claims Information

1. If the caller is reporting missing or incorrect MyMedicare.gov Web Portal claims information, **do not** transfer to the Medicare Beneficiary Portal (MBP) Technical Support team. This is **not** a technical issue.
    - Please use NGD to assist the caller.
    - If required, make the appropriate transfer to a Claims CSR.
2. If the caller has questions about a deceased beneficiary, transfer to a Claims CSR.

****CLAIMS CSRS ONLY****

3. If you are unable to locate the missing or incorrect MyMedicare.gov Web Portal claims information in NGD, please advise the caller to speak with his or her healthcare provider and have the claim(s) resubmitted.
4. If a beneficiary has been deceased for more than six months, access the Disclosure Desk Reference (DDR) to determine to whom you can release information and the type of information you can release.

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Call the Help Queue.

****CSR NOTE: If the caller requests a retroactive change**, warm transfer to the Help Queue and explain that the caller qualifies for the MA marketing misrepresentation SEP and is requesting a retroactive change. The Help Queue will submit this as an **Enrollment Exception (EE)** by using the script in the PDP Plan Referral Survey.****

- If you submitted an enrollment, provide the plan name and contract number to the Help Queue.
- If you processed a disenrollment, explain to Help Queue all actions that were taken during the call, including any enrollments or disenrollments (including any actions taken by another CSR).
- The **Help Queue agent** needs to enter the "Bypass" Code and NOT the contract number into the Complaint Contract Number field. Help Queue should follow this script for additional instructions regarding this EE.

Medicare Cost and Premiums

START: Your out-of-pocket costs for Medicare include premiums, deductibles, copayments and coinsurance.

Choose the appropriate issue below:

Medicare Part A & B Costs	Medicare Part A & B Premiums	Medicare Advantage Plan Costs

Part A & B Deductible

Part A & B Coinsurance and Copayments

Benefit Periods and Lifetime Reserve Days

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Part A & B Deductible

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The deductible is the amount you must pay for health care, before Medicare begins to pay. These amounts may increase each year.

The Medicare Part A deductible for 2007 is $992 ($952 in 2006) for each benefit period. The Part B deductible for 2007 is $131 ($124 in 2006) for the calendar year (January 1 through December 31)..

A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received any hospital or skilled nursing facility care for 60 days in a row.

You can look on your Medicare Summary Notice (MSN) to find out if you have met your deductible. After Medicare processes your claims, you will receive an MSN that explains the payment or denial. If you have not yet met your deductible, the MSN will tell you how much was applied toward your deductible. I can also look up that information for you.

When you visit a health care provider, he or she may ask you if you have met your Medicare deductible. If you have not, your health care provider can collect any deductible amount that you have not met if a deductible applies to the service. Medicare will not start paying benefits until you have met your deductible. Your deductible is calculated in the order of which the claim was filed, not in the order of the dates on which the services were received. Your health care provider cannot ask you to pay more than the amount of your Medicare-approved service. For example, if you have a $60 office visit and have not met your $131 Part B deductible, the doctor can collect the $60 and no more.

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TIP BOX:

SCRIPT = Part A & B Coinsurance to explain what Medicare pays after the deductible is met.
SCRIPT = Benefit Period/Lifetime Reserve Days for more information about the benefit period.
REFERRAL = State Medical Assistance Office (Medicaid) if beneficiary needs help paying deductibles.
TIP = If beneficiary has another insurance, it may assist with paying for the deductible.
REFERENCE MATERIAL = Deductible amounts for 2005 can be found in related reference materials "Part A Deductible & Coinsurance Job Aid."

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Part A & B Coinsurance and Copayments

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Coinsurance is the percent of the Medicare-approved amount that you have to pay after you have paid the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%). A copayment is an amount you pay for each medical service. A copayment is usually a set amount of money.

The Medicare Part A deductible for 2007 is $992.00 ($952.00 in 2006) per benefit period. Copayment amounts for Part A services in 2007 are:

- $248 ($238 in 2006) per day for days 61-90 of a hospital stay.
- $496 ($476 in 2006) per day for days 91-150 of a hospital stay (lifetime reserve days).
- All costs for each day beyond 150 days.
- Nothing for the first 20 days in a skilled nursing facility for each benefit period.
- Up to $124.00 ($119 in 2006) per day for days 21-100 in a skilled nursing facility for each benefit period.
- All costs beyond the 100th day in a skilled nursing facility for each benefit period.
- A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care you receive under the hospice benefit.

For Part B services, the coinsurance is 20% of the Medicare-approved amount after you meet the $131 ($124 in 2006) deductible.

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TIP BOX:

REFERRAL = State Medical Assistance Office (Medicaid) if beneficiary needs help paying coinsurance and/or copayments.
REFERENCE MATERIAL = Coinsurance and copayment amounts for 2005 can be found in related reference materials "Part A Deductible & Coinsurance Job Aid."

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Benefit Periods and Lifetime Reserve Days

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Benefit Periods:
Medicare uses a period of time called a benefit period to keep track of how many days of inpatient hospital care and skilled nursing facility (SNF) benefits you use. A benefit period begins the day you go to a hospital or SNF. It ends when you have been out of the hospital or SNF for 60 days in a row. There is no limit to the number of benefit periods you can have. You must pay the inpatient deductible, coinsurance, and copayments for each benefit period.

Medicare will cover up to 100 days in a SNF during one benefit period. For the first 20 days, Medicare pays the full cost. For days 21 through 100 Medicare pays all but the daily copayments.

Multiple hospital and skilled nursing facility admissions not separated by 60 days out of the facility are considered to be in one benefit period.

Lifetime Reserve Days for Inpatient Hospital Care:
Medicare will pay part of the costs of inpatient hospital care for up to 90 days in a benefit period. After that time, you will have to pay all costs unless you use your reserve days. You have 60 reserve days that can be used if your hospital stay exceeds 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day Medicare pays all covered costs except for a daily copayment of $496 for 2007 ($476 for 2006).

Lifetime reserve days do not apply to skilled nursing care.

****CSR Note:** You can find the number of lifetime reserve days a beneficiary has left on the Part A and B Benefits tab.**

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Part A & B Premiums

Automatic Premium Payment or Payment by State

Premium-Free Medicare Part A

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Part A & B Premiums

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A premium is the amount you pay monthly for your Medicare coverage.

Part A Premium Information
Most people get Part A automatically and do not have to pay a premium because they or their spouse paid Medicare taxes while they were working. However, for those who must pay for Part A, the monthly premium for 2007 is $410.00 ($393.00 in 2006). If you do not sign up for Part A during a designated enrollment period, you may have a surcharge added to your Part A premium due to late enrollment. Please contact the Social Security Administration for more information.

Part B Premium Information
You must pay your Medicare Part B premium to get Part B benefits. In some cases, this amount may be higher if you did not choose Part B when you first became eligible at age 65. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it, except in special cases. You may have to pay this extra 10% for the rest of your life.

If you need help paying your Part B premium, you should contact your State Medical

Assistance Office (Medicaid).

Enrolling in Part B is your choice. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Federal Employee Health Benefits Program (FEHBP) payment. If you do not get any of these payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you do not get your bill by the 10th, you should call the Social Security Administration.

The 2007 Income-Related Part B Premium:

If your modified adjusted gross income (MAGI) is above $80,000 (single) or $160,000 (married couple), you will pay a higher monthly premium than the standard $93.50. The Social Security Administration (SSA) will use the income reported on your 2005 IRS income tax return to determine your 2007 Part B premium. If your 2005 tax return is unavailable, SSA will use the income reported on your 2004 return. If your income has decreased since 2005, you can contact SSA to ask for a new decision about your Part B premium.

You should have received a letter from the Social Security Administration to let you know if your Part B premium will increase based on your income. If you disagree with the decision about your income-related Part B premium in this letter, you have the right to appeal within 60 days after you get this letter. SSA may start withholding your increased premiums before a decision is made on your appeal.

If you believe that the income information that SSA used to determine your increased premium is not correct, you may contact SSA to request a new decision.

****CSR NOTE:** See "Sample 2007 SSA Cost of Living Allowance (COLA) Notice" for more information on the income-related premium and the appeal process. If a caller disagrees with the decision about his or her income-related Part B premium, disagrees with the information used to determine his or her Part B premium increase, or has specific questions about his or her Part B premium, please refer him or her to the SSA (1-800-772-1213).**

Part B Monthly Premium		
	Beneficiaries who file an individual tax return with income	Beneficiaries who file a joint tax return with income
Your 2007 Part B Monthly Premium Is	**If Your Yearly Income Is**	
$93.50	$80,000 or less	$160,000 or less
$105.80	$80,001 - $100,000	$160,001 - $200,000
$124.40	$100,001 - $150,000	$200,001 - $300,000
$142.90	$150,001 - $200,000	$300,001 - $400,000

$161.40	Above $200,000	Above $400,000

Part B Monthly Premium Beneficiaries who are married, but file a **separate tax return** from their spouse and lived with their spouse at some time during the taxable year (2006)	
Your 2007 Part B Monthly Premium is	**Beneficiaries who are married but file a separate tax return from their spouse**
$93.50	Under $80,000 or less
$142.90	$80,001 - $120,000
$161.40	Above $120,000

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TIP BOX:

SCRIPT = EE SLMB QMB QI-1 Medicare Savings Program for information about programs that can help pay all or part of your Medicare premiums, deductibles or coinsurance.
TIP = There is no Part A premium if the person with Medicare or his or her spouse has 40 or more quarters of Medicare-covered employment.
TIP = The Part A Premium is $226 in 2007 ($216 in 2006) for people having 30-39 quarters of Medicare-covered employment.
TIP = Modified adjusted gross income (MAGI) is the total of adjusted gross (taxable) income and certain forms of tax exempt income, most often tax exempt interest.

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Automatic Premium Payment or Payment by State

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Your Part B premium is based on your annual income. Most people will pay a standard monthly premium and some people will pay a higher premium based on their annual income. These amounts may change each year. The standard Part B monthly premium will be $93.50 for 2007 ($88.50 in 2006).

Your Part B premium will be automatically deducted from your Social Security, Railroad Retiree, or Federal Employee Health Benefits Program (FEHBP) payment. The premium cannot be deducted from any private pension check.

Usually your premium is deducted from your Social Security, Railroad Retirement Board, or FEHBP payment the month your Part B starts. If the deduction starts before your Part B starts, please contact your local Social Security, Railroad Retirement, or FEHBP office to confirm this is correct. If you do not get any of these payments, you will receive a bill for your Part B premium.

Medicare drug coverage:
Premium payments for Medicare drug plans can be deducted from Social Security payments. If you have a question about your premium, you need to contact your drug plan. The Social Security Administration does not answer questions about your drug plan premiums. **SCRIPT = Drug Coverage Cost Information.**

If the state is paying your Medicare Part B premium:
You should not receive a premium notice if your state Medicaid agency is paying your Medicare Part B premium. It should not be taken out of your Social Security payment. There may be a lag time between when the state decides that you are eligible for assistance and when the state's premium payments actually begin. If you have questions about premium payments, contact your State Medical Assistance Office (Medicaid). If the state is paying your Part B premium and it is also being taken out of your Social Security payment, please call the Social Security office. The Social Security office can answer questions about a refund.

If the state pays your Part B premium surcharge, you still must pay your Part B base premium. You will either be billed for it or the base premium will be taken out of your monthly Social Security check, Railroad Retirement Board check or Federal Retirement benefit payment.

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TIP BOX:

REFERRAL = Social Security Administration
REFERRAL = Railroad Retiree Board for railroad retirees
REFERRAL = Federal Employee Health Benefits Program (FEHBP) for federal government retirees
REFERRAL = State Medical Assistance Office (Medicaid)
WEB = www.socialsecurity.gov
SCRIPT = If the caller has questions about his or her prescription drug plan premium payment options, refer to Drug Coverage Cost Information.
REFERRAL = If your state is paying your Medicare Advantage Plan premium and you have questions about those payments, please contact your State Medicaid Office.

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Premium-Free Medicare Part A

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If you are already getting Social Security or Railroad Retirement benefits, you will get Medicare Part A automatically when you turn age 65. If you are close to age 65 and are not yet getting Social Security or Railroad Retirement benefits or Medicare Part A, you can apply for both at the same time. You can also apply for Medicare Part A only. Most people do not pay a monthly premium for Medicare Part A because they or their spouse paid Medicare taxes while working. This is called premium-free Medicare Part A.

You can get Part A at age 65 without having to pay premiums if:

- You are receiving retirement benefits from Social Security or the Railroad Retirement Board.
- You are eligible to receive Social Security or Railroad benefits but you have not yet filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under age 65, you can get Part A without having to pay premiums if:

- You have been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months. Your 24-month waiting period will be waived if you have been diagnosed with Amyotrophic Lateral Sclerosis (ALS). This disease is commonly known as Lou Gehrig's Disease.
- You are a kidney dialysis or kidney transplant patient. When you first enroll in Medicare based on End Stage Renal Disease (ESRD) and you are on dialysis, your Medicare coverage usually starts the 4th month of dialysis treatments.

If you or your spouse did not pay Medicare taxes while you worked, and you are age 65 or older, you still may be able to buy Medicare Part A. If you aren't sure if you have Medicare Part A, look on your red, white, and blue Medicare card. It will show "Hospital (Part A)" on the lower left corner of the card. You can also call the Social Security Administration or visit your local Social Security office for more information about buying Medicare Part A. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office.

TOP BACK

TIP BOX:

REFERRAL = Social Security Administration
REFERRAL = Railroad Retirement Board
WEB = www.socialsecurity.gov
SCRIPT = EE Buying Medicare Part A and B
SCRIPT = EE Medicare Auto Enrollment Initial Enrollment Packet

TOP BACK

Medicare Advantage Plan Costs

TOP BACK

Each Medicare Advantage Plan is different. Your costs depend on:

- Whether the plan charges a monthly premium in addition to your monthly Medicare Part B.
- The prescription drug coverage premium, where applicable.
- How much you pay for each visit or service (copayments).
- The type of health care you need and how often you get it.
- The types of extra benefits you need, and whether the plan covers them.
- Whether you follow plan rules. If you do not, you may have to pay the full cost for your care.

If you have a question about your premium, you need to contact your Medicare Advantage Plan. The Social Security Administration does not answer questions about your Medicare Advantage Plan premiums.

Each year, Medicare Advantage Plans make business decisions about the benefits they offer and the premiums they charge. Your plan must inform you about any changes in advance by sending you an Annual Notice of Change letter in October of each year.

You can always choose to get services not covered by your Medicare Advantage Plan and pay for these services yourself.

TOP BACK

TIP BOX:

TIP = If caller wants plan premium information, use the MA-PDP tab.
REFERENCE MATERIAL = 2007 Annual Notice of Change (MA-Only)
REFERENCE MATERIAL = 2007 Annual Notice of Change (MA-PDP)
SCRIPT = Drug Coverage Cost Information, if the caller has questions about his or her prescription drug plan premium payment options.

Medicare Part B helps pay for the following services if they are medically necessary based on Medicare requirements:

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic tests (such as CAT Scans, MRI's and PET Scans)
- Clinical laboratory services (such as blood tests, urinalysis and more) Medicare pays 100% even if you have not met your yearly Part B deductible.
- Ambulatory surgery center facility fees for approved procedures
- Home health services
- Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen and walkers)
- Blood
- Physical, occupational and speech therapy
- Mental health services (Medicare pays 50% of the approved amount after you have met your Part B deductible.)
- Second surgical opinions
- Ambulance services
- Emergency room services
- Preventive Services

Medicare pays 80% of the Medicare-approved amount after you have met your yearly $131 Part B deductible ($124 in 2006).

Medicare Part B does not cover:

- Acupuncture
- Routine foot care (with only a few exceptions)
- Hearing aids and hearing exams for the purpose of fitting a hearing aid
- Hearing exams (screening) unless ordered by your doctor
- Routine or yearly physical exams (Except for the Welcome to Medicare Physical Examination)
- Routine eye care and most eyeglasses, or
- Cosmetic surgery or
- Prescription drugs or medical care received outside the United States except under limited circumstances.

ADDITIONAL INFORMATION: Original Medicare does not cover gym memberships. However, some Medicare Advantage Plans, Medicare Health plans, and Medigap policies may offer coverage for fitness programs like SilverSneakers. If you are in a Medicare Advantage Plan, other Medicare Health Plan, or have a Medigap policy, please contact the plan to see if it offers that type of coverage.

CC Preventive Services Overview

Preventive services help you stay healthy and can help find health problems early when they are most able to be treated. Medicare pays for many (but not all) preventive services.

Preventive services may include:

- **Mammography for Breast Cancer Screening**
- **Pap Smears and Pelvic Exams for Cervical Cancer Screening**
- **Tests for Colorectal Cancer Screening**
- **Bone Mass Measurements for Osteoporosis**
- **Diabetes Screening, Self-Management and Blood Glucose Monitoring**
- **Medical Nutrition Therapy (for Medicare beneficiaries with diabetes, renal disease or post transplant)**
- **Flu, Pneumonia, Hepatitis B and Shingles Vaccinations**
- **Prostate Cancer Screening**
- **Cardiovascular Screening Blood test**
- **Ultrasound Screening for Abdominal Aortic Aneurysms**

****CSR NOTE:** If caller would like to review their **Medicare-covered preventive service eligibility dates,** click **HERE** **(For Preventive Services Lookup).**

Preventive services also include counseling and information services to help you take care of yourself.

If you are new to Medicare you will be eligible for a one-time **"Welcome to Medicare"** physical exam. The exam is available during the first 6 months you have Medicare Part B.

In most cases, you must pay a coinsurance of **20%** of the **Medicare-approved amount** after you meet your yearly Part B deductible. For some preventive services, Medicare pays **100%** and does not apply the Medicare yearly Part B deductible or coinsurance. Whether or not the coinsurance or deductible is applied depends on which preventive service you receive.

You must have Medicare Part B to qualify for the Medicare Preventive Service benefits.

Your doctor or healthcare provider may do exams or tests that Medicare doesn't cover, or may recommend that you have tests more or less often than Medicare covers them. Talk to your doctor or health care provider to find out how often you need these exams.

****CSR NOTE**: If the person with Medicare needs detailed information about different Preventive Services such as how procedures are performed, they should contact their provider.

TIP BOX

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Mammography for Breast Cancer Screening

Screening Mammograms

As part of Medicare's Preventive Service benefit, all women with Medicare age 40 and older are eligible for a screening mammogram every 12 months. Eligibility depends on the date of your last screening mammogram.

EXAMPLE: If a caller had a screening mammogram on September 12 of the current year, they would be eligible for another screening mammogram on September 1 of the following year. They would not have to wait until the actual day, just the same month. This rule applies to screening mammograms.

For screening mammograms, you must pay **20%** of the **Medicare-approved amount**. The Medicare Part B deductible will not be applied to a screening mammogram.

If you are in a Medicare Advantage Plan, check with your plan to find out what your out-of-pocket costs will be.

Medicare also covers **digital technologies** for mammogram screening.

Diagnostic Mammograms

Medicare will cover a diagnostic mammogram for men and women with Medicare. Your physician may request a diagnostic mammogram when there is a reasonable suspicion that an abnormality may exist in the breast. You must pay **20%** of the Medicare-approved amount after you have met your yearly $131 Part B deductible ($124 in 2006).

ADDITIONAL INFORMATION:
Medicare will pay for more than one diagnostic mammogram in a year if:

- Ordered by a doctor, and
- Symptoms of some type of illness or problem are present, such as breast cancer.

Medicare will also pay for one baseline mammogram for women with Medicare between ages 35 and 39.

****CSR NOTE:**

- www.medicare.gov website (click on Preventive Services, then Cancer, then Breast Cancer Screening Mammograms) has information on mammograms and breast cancer
- www.cancer.gov website has information on mammograms and breast cancer.

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A screening mammogram is a mammogram used for the purpose of identifying if breast cancer is present in a person that has certain risk factors.

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A diagnostic mammogram is a mammogram used for the purposes of confirming the presence of breast cancer.

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Abdominal Aortic Ultrasound Screening

Medicare covers a one-time ultrasound screening for abdominal aortic aneurysms. Those at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound during their **Welcome to Medicare Physical Exam**. Your physician will determine if you are at high risk for abdominal aortic aneurysms.

You pay **20%** of the **Medicare-approved amount.** The Medicare Part B deductible will not be applied for the Abdominal Aortic Ultrasound screening.

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Pap Smears and Pelvic Exams for Cervical Cancer Screening

Medicare covers Pap smears and pelvic exams to check for cervical and vaginal cancers. A clinical breast exam is also covered to check for breast cancer.

All women with Medicare are eligible to receive a covered Pap smear and pelvic exam once every 24 months.

However, Medicare will cover a Pap smear and pelvic exam every 12 months, if:

- You are a woman of childbearing age and have had an abnormal Pap smear within the past 36 months, or
- You are at high risk for cervical or vaginal cancer.

EXAMPLE:If you had a Pap smear and pelvic exam on September 12 of the current year, you would be eligible for another Pap smear and pelvic exam on September 1 of the following year. You would not have to wait until the actual day, just the same month.

You have to pay 20% of the Medicare-approved amount for the Pap smear collection and pelvic and breast exams, and nothing for the Pap smear lab. You do **NOT** have to meet your $131 Part B deductible first.

The Centers for Medicare & Medicaid Services (CMS) and the National Cancer Institute (NCI) are conducting an education program about the importance of Pap tests in decreasing the number of cases of cervical cancer in women with Medicare. You can receive more information on Pap tests and cervical cancer by calling the **National Cancer Institute**.

CSR NOTE:

- Medicare does not cover the human papillomavirus (HPV) screening test or the vaccine.
- Please use the Agent Partner Search screen to find the phone number and log the referral for the National Cancer Institute.
- You can also go to www.medicare.gov, click on Preventive Services and then Cancer - Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exams). This has good information on cervical cancer and what Medicare is doing to help.

TIP BOX

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Tests for Colorectal Screening

Medicare helps pay for colorectal screening tests. Colorectal cancer is defined as cancer of the colon or rectum. Both men and women are at risk for colorectal cancer. The disease is most common among people age 50 and older and the risk increases with age. Colorectal cancer is the nation's second leading cause of cancer deaths.

Regular screening can help to prevent colorectal cancer by finding growths (called polyps) so they can be removed before they turn into cancer and to find colorectal cancer early when the chance of being cured is good.

All people with Medicare age 50 or older are eligible for colorectal screenings.

You pay nothing for the fecal occult blood test. For all other screening tests, the coinsurance or copayment applies, but the Medicare Part B deductible is waived. However, if a screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and the deductible is applied. If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department or ambulatory surgical center, you pay 25% of the Medicare-approved amount.

Medicare covers:

- A fecal occult blood test (FOBT) every 12 months,
- A flexible sigmoidoscopy once every 48 months, and
- A colonoscopy once every 24 months if you are at high risk for colorectal cancer. If you are not at high risk, Medicare covers this test every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.
- Your doctor can give you a barium enema test instead of a sigmoidoscopy or colonoscopy, and Medicare will help pay for it.

****CSR NOTE:** For all four tests above, let the caller know that they do not have to wait until the actual day they had the exam, just the same month.

Talk to your doctor about the screening options that are right for you. You need an order from your doctor for the specific test they think is best.

ADDITIONAL INFORMATION:

Only a licensed physician can determine "high risk." The factors that physicians normally use to base their decision for determining high risk are:

- Present medical condition
- Previous personal medical history
- Family history

CSR NOTE:

- www.medicare.gov website (click on Preventive Services then Cancer, then Colon Cancer Screening (Colorectal). This has good information on colorectal cancer and what Medicare is doing to help.
- www.cdc.gov/cancer has good information on screening on the Preventive Cancer Screening and Vaccination link.

TIP BOX

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Bone Mass Measurements for Osteoporosis

Medicare Part B provides coverage for a bone mass measurement test if you are at risk for bone loss or osteoporosis. Medicare covers this test once every 24 months or more frequently if medically necessary.

Your doctor can help you decide if you are at risk for osteoporosis or if you meet any of the following criteria for bone loss:

- A woman who is estrogen-deficient and at clinical risk for osteoporosis.
- A person whose x-rays show possible osteoporosis, osteopenia (bone loss), or vertebral fractures.
- A person getting (or expecting to get) glucocorticoid (steroid) therapy that is equal to at least 7.5 mg of prednisone per day, for more than 3 months.
- A person with primary hyper-para-thyroidism (excessive production of the parathyroid hormone).
- A person being monitored to see how well an FDA-approved osteoporosis drug is working.

If you had a bone mass measurement test on September 12 of the current year, you would be eligible for another bone mass measurement test on September 1 of the second year. You would not have to wait until the actual day, just the same month.

You must pay **20%** of the Medicare-approved amount after you have met your yearly $131 Part B deductible ($124 in 2006).

CSR NOTE:

- www.medicare.gov website (click on Preventive Services then Bone Mass Measurement). This has good information on osteoporosis and bone mass and what Medicare is doing to help.

TIP BOX

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Diabetes Screening, Self-Management and Blood Glucose Monitoring

Diabetes Screening Test
Medicare covers a Diabetes Screening test (Fasting Plasma Glucose Test) to check for diabetes.

Medicare may cover one screening test every 6 months for those diagnosed with pre-diabetes. Medicare may also cover one screening test every 12 months for individuals not diagnosed with pre-diabetes or who have never been tested.

Keep in mind that this is a screening test for diabetes. If you have already been diagnosed with diabetes, you will not qualify for coverage for this screening.

Medicare pays **100%** for this test. There is **no coinsurance or Part B deductible** for diabetes screening lab tests. This means that there is no out-of-pocket cost to you. You should talk to your doctor to see if this test is right for you.

Diabetes Self-Management Training

Medicare also helps pay for diabetes self-management training for people with Medicare who have diabetes and are at risk for complications from diabetes. The diabetes self-management training must be requested by your doctor or other health care provider.

A self-management training program teaches you to manage your diabetes. This includes education on self-monitoring of blood glucose, diet and exercise, and an insulin treatment plan made especially for the person who is insulin-dependent.

You will be responsible for **20%** of the Medicare-approved amount for the self-management training program after you meet your yearly $131 Part B deductible ($124 in 2006).

****CSR NOTE:** Refer the caller to their physician if they want to know if they qualify for a diabetes screening test.

TIP BOX

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Medical Nutrition Therapy (for Medicare beneficiaries with diabetes, renal disease or are post-transplant patients)

Medicare covers medical nutrition therapy (MNT) when referred by a physician and provided by registered dieticians and other nutrition professionals. Only people with Medicare who have diabetes, kidney disease, or are post-transplant patients can receive medical nutrition therapy.

Medical nutrition therapy services are covered for 3 years after a kidney transplant.

If you have already been diagnosed with diabetes, renal disease, or those who are post-transplant patients, your doctor may decide to refer you to someone who can do an assessment to see if you would benefit from medical nutrition therapy. Treatment usually includes therapy which helps to correct illness caused by diet and counseling to help you control nutrition-related illnesses.

ADDITIONAL INFORMATION:
People with Medicare who have diabetes or kidney disease (ESRD) can receive both medical nutrition therapy and diabetes self-management training in the same year; however, they cannot have both services on the same day.

Dietary foods, drinks, supplements and vitamins are NOT covered under the Medicare program.

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Flu, Pneumonia, Hepatitis B and Shingles Vaccinations

Flu Shot Overview

Medicare pays for a flu shot once every flu season. The flu is a serious illness that can lead to pneumonia. It can be dangerous for people over age 50 or for those with serious health conditions. The shot is updated each year for the most current flu virus. The flu shot only helps protect you from the flu for one year.

Flu Shot Payment and Locations

There is **no deductible or coinsurance** for the flu shot. You should try to get it from a doctor or provider who will bill Medicare; that way you will not have to pay anything for the shot. (For the 2006 flu season, you could **NOT** have filed your own claim for the cost of the flu shot.) Before you receive the flu shot, you should ask the person who is giving the shot if they will bill Medicare. If you go to a doctor or provider who will not bill Medicare, and there is a charge, you will be responsible for paying the entire amount.

****CSR NOTE:** Refer caller to doctor if they have questions on when the flu vaccine will be available or to their local State Health Department for flu shot locations. Flu shots may be given at pharmacies or grocery stores. Beneficiaries may not file their own **1490S Claim Form.**

Pneumonia Shot

Medicare pays for a pneumonia shot. Most people only need to get this shot once in their life. Check with your doctor to see what your needs are. If your doctor accepts assignment, you will not have to pay anything for the shot.

Hepatitis B Shot

Medicare will pay for a Hepatitis B shot if you are at medium or high risk for Hepatitis B. Those at risk include people with End-Stage Renal Disease or hemophilia.

Check with your doctor to find out if you are at risk.

You must pay **20%** of the Medicare-approved amount after you have met your yearly Part B deductible.

Shingles Vaccine

The shingles vaccine is **not** covered by Medicare Part B; however, it **may** be covered by Medicare drug plans. If you are enrolled in a Medicare drug plan, you will need to contact your plan to find out if it is covered. If your drug plan doesn't cover the vaccine, you can ask them for an exception.

For 2007 **only**, Medicare Part B will cover the administration of vaccines that are covered by your Medicare drug plan. In 2008, your Medicare drug plan will pay for these administration fees and will continue to cover the vaccine, as long as it's on their formulary.

ADDITIONAL INFORMATION:
Nursing homes serving Medicare and Medicaid patients must provide the flu and pneumonia shots to their residents. However, the resident or the resident's family can refuse the shots.

TIP BOX

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Prostate Cancer Screening

Medicare helps pay for prostate cancer screenings for all men with Medicare age 50 and older.

The digital rectal exam is covered once every 12 months. You must pay for **20%** of the **Medicare-approved amount** after the yearly Part B deductible.

The Prostate Specific Antigen (PSA) test is also covered once every 12 months. Medicare will pay **100%** of this test. (Coinsurance and Part B deductibles do not apply to the PSA test.)

ADDITIONAL INFORMATION:
Eligibility is based on the date of your last screening service.

EXAMPLE: If the caller has a screening test/exam on December 12 of the present year, they would be eligible for another test/exam on December 1 of the following year. The beneficiary would not have to wait until the actual day, just the same month.

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Cardiovascular Screening Blood Tests

Medicare will cover three cardiovascular screening tests. These tests check your cholesterol and other blood fat (lipid) levels. The three cardiovascular tests covered by Medicare are:

- Total Cholesterol test,
- Cholesterol test for High Density Lipoproteins, and,
- Triglycerides test.

Medicare will pay for each of these three tests once every 5 years if you have an order from your doctor for the specific test they think is best.

High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol and can help you find cardiovascular problems in the early stages.

There is **no coinsurance or Part B deductible** for cardiovascular screening lab tests. You should talk with your doctor to see if these tests are right for you.

TIP BOX

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Welcome to Medicare Physical Exam

Medicare helps cover a one-time preventive physical exam in the first 6 months that you have Medicare Part B.

The exam will include a thorough review of your health. You will also receive education and counseling about the preventive services you need such as certain screenings and shots, and referrals for other care if you need it.

The exam may be performed either at a doctor's office or at another qualified non-physician practitioners (NPP) office, clinic or at an outpatient hospital setting where a physician, or other qualified NPP is providing these services.

The **Welcome to Medicare** physical exam is a great way to get up-to-date information on important screenings and shots. It also gives you a chance to talk with your doctor about your family history and how to stay healthy. The Welcome to Medicare exam does not include payment for clinical laboratory tests. However, the physician can bill separately for those services that are currently covered and paid for by Medicare Part B, which includes clinical lab tests.

You only pay **20%** of the **Medicare-approved amount** for the Welcome to Medicare physical exam after you meet the yearly $131 Part B deductible ($124 in 2006).

ADDITIONAL INFORMATION:
These benefits may be used to screen for illnesses and conditions that, if caught early, may be treated and managed, and may result in fewer serious health problems. For example, those at risk for **abdominal aortic aneurysms** may get a referral for a one-time screening ultrasound during their Welcome to Medicare physical exam.

You should bring your medical records to your doctor's appointment. You should also bring information on your family medical history and a list of prescription drugs that you are taking and how often you take them. The Welcome to Medicare physical exam can only be provided by a physician or other qualified non-physician practitioner (NPP) such as a nurse practitioner or clinical nurse specialist or physician assistant.

The law allows this coverage for people with Medicare whose Part B began on or after January 1, 2005, and received the exam within 6 months of the effective date of their initial Part B coverage.

Those who began Medicare Part B **before** January 1, 2005, are not eligible for this exam.

TIP BOX

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TIP BOX

SCRIPTS

- **CC Prior Determination of Medicare Coverage FFS Referral** if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.
- EE How Medicare Advantage Plans Work if caller has questions about a Medicare Advantage plan.

TRANSFER

- Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or

outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

TIP

- If the beneficiary needs detailed information about different preventive services such as how procedures are performed, they should contact their provider.

REFERENCE MATERIAL

- Medicare & You Handbook 2007 page 10-18

FULFILLMENT

- Your Guide to Medicare Preventive Services - #10110
- Women with Medicare - #02248

CLAIMS TIER II CSR Tips:

TRANSFER = Local Contractors for questions that can only be answered by the contractor.

- Refer to **Fiscal Intermediary** for items or services provided in a hospital or other facility if caller has questions that can only be answered by the contractor.
- Refer to the **Carrier** for doctor or outpatient services if caller has questions that can only be answered by the contractor.
- Refer to the **DME MAC** for supplies if caller has questions that can only be answered by the contractor.
- Refer to the **RHHI** for services performed by a home health agency or hospice if caller has questions that can only be answered by the contractor.

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CC Prior Determination of Medicare Coverage FFS Referral

- I am able to give you general Medicare coverage information.
- Medicare does not pre-authorize coverage for medical services.
- Medicare will make a coverage decision when your health care provider sends a claim to Medicare.
- Your health care provider should explain to you if Medicare typically covers the services s/he recommends for you.

****If a provider told the caller to get authorization:**
If the caller states that his or her provider told him or her to call Medicare to get pre-authorization, tell the caller to advise his or her provider that Medicare does not pre-authorize coverage for medical services.

****CSR NOTE:** If the beneficiary provides a procedure code and wants to know how much Medicare would pay, **READ**: The claim must be submitted in order for Medicare to determine coverage and payment.

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Medically Necessary

Services or supplies that:

- are proper and needed for diagnosis, or treatment of your medical condition
- are provided for the diagnosis, direct care, and treatment of your medical condition
- meet the standards of good medical practice in the medical community of your local area, and
- are not mainly for the convenience of you or your doctor.

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Medicare Approved Amount

In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

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Preventive Services Lookup

I will be happy to discuss your Medicare-covered preventive service eligibility dates.

Before I continue, I need to confirm that I am speaking to the person with Medicare or that the person with Medicare is available to verify some personal information.

YES	NO
Is Available	**Is not Available**

****Read if caller is the beneficiary and did not pass disclosure and is interested in Preventive Services.****

Unfortunately, I am unable to look up that information for you today. Please call back when you have:

- your Medicare number,
- your date of birth, and
- whether or not you have Part B coverage.

****CSR NOTE**: Caller may be off by 2 years, but the day and month must be exact.**

****Read if caller is someone other than the person with Medicare**** Unfortunately, I am unable to look up that information for you today. Only the person with Medicare can get information about his or her preventive service history or the date when they will be eligible for the next preventive service appointment. If possible, please call back with the person with Medicare and have him or her take the call, or have the person with Medicare call back to find out when they will be eligible for their next preventive service appointment.

End of Script

TIP BOX

Are you in a Medicare Advantage Plan?

YES / **NO**

Refer the caller to their Medicare Advantage Plan.

End of Script

TIP BOX

TOP BACK

Do you have Medicare Part B?

YES / NO

You must have Medicare Part B to qualify for Preventive Services. We cannot look up Preventive Services records if you do not have Part B.

End of Script

TIP BOX

TOP **BACK**

Are you new to Medicare?

YES / **NO**

When did your Part B coverage start? The date is on your Medicare card.

If your initial Part B coverage began on or after January 1, 2005, you may be eligible for a one-time Welcome to Medicare physical exam. The physical exam is available in the first 6 months that you have Medicare Part B.

Continue

COMPLETE THE PREVENTIVE SERVICES PROCESS

REFERRAL:

- Social Security Administration, if the person with Medicare gives information that is different from what is on the Beneficiary Disclosure tab in NGD, does not pass disclosure, and needs assistance with verifying or correcting records

End of Script

TIP BOX

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A test where the doctor puts a short, thin, flexible, lighted tube into your rectum and checks for polyps or cancer inside the rectum and lower third of the colon.

TOP BACK

A test where you receive a kit from your doctor or health care provider. You take small stool samples at home and return the test cards to the doctor or a lab. The stool samples are checked for blood.

TOP BACK

A test where the doctor puts a thin, flexible, lighted tube into the rectum to check for polyps or cancer inside the rectum and the entire colon.

TOP BACK

A barium enema is given in order to perform an x-ray exam of the large intestines; pictures are taken after a barium sulfate contrast medium is inserted into the rectum.

TOP BACK

Both digital and film-based mammograms involve compressing the breasts between two plastic plates and taking pictures. But **digital technology** records the images electronically at greater speed and uses less radiation. This is especially important for women with dense breast tissue because the film images are white, and can hide cancerous lesions.

If you have additional questions about digital technology, please contact your physician.

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CC Part A Covered/Noncovered Services

PART A COVERED SERVICES:

- Inpatient care in hospitals, (including critical access hospitals);
- Skilled nursing facilities;
- Hospice care;
- Respite care in hospice;
- Home health care;
- Beneficiary access to religious nonmedical health care institution (RNHCI) services;
- Inpatient mental health/ psychiatric care;
- Inpatient alcohol or substance abuse treatment; and
- Part A blood (see the restrictions under noncovered services below).

PART A NONCOVERED SERVICES:

- private duty nursing;
- a television or telephone in your room;
- a private room unless medically necessary;
- custodial care, assisted living, adult daycare, or reimbursement for family members; and
- you must also pay for the first three pints of blood unless the blood deductible has been met.

****Read if caller asks why a particular service is not covered.****
Medicare is a health insurance program that was established to help decrease medical costs for seniors. Medicare does not cover all services and supplies.

CSR Tips:

REFERENCE MATERIAL = Part A Covered/Noncovered Services

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

INPATIENT HOSPITAL

Medicare Part A helps pay for up to 90 days of inpatient hospital care in each benefit period. This includes care in a critical access hospital and inpatient mental health care. The following inpatient services are covered by Medicare:

- Semi-private room and board (2-4 beds in a room);
- All meals and special diets;
- General nursing;
- Physical, occupational, and speech-language therapy;
- Drugs;
- Blood transfusions;
- Medical supplies; and
- Use of equipment (such as wheelchairs).

Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

You will be responsible for paying the inpatient hospital deductible, coinsurance, and any noncovered services you may get. Medicare will cover the rest. Hospitals must always accept the Medicare-approved amount.

In 2007, the amounts you pay for each benefit period are:

- The deductible of $992 ($952 in 2006) for a hospital stay of 1-60 days;
- $248 ($238 in 2006) per day for days 61-90 of a hospital stay;
- $496 ($476 in 2006) per day for days 91-150 of a hospital stay (lifetime reserve days); and
- All costs for each day beyond 150 days.

Medicare doesn't pay for private duty nursing, a television or telephone in your room, or a private room, unless it is medically necessary.

If you leave the hospital against medical advice, the hospital may bill for an inpatient admission as long as there is a doctor order, a formal admission process and inpatient services.

- Once you have been admitted and some inpatient services have been provided, an inpatient admission may be billed no matter how much time you have spent in the hospital.
- If you refuse admission and there is no signed permission slip to be admitted, the hospital cannot bill the admission.
- For a hospital to bill for an inpatient admission, it must be medically necessary for Medicare to cover the admission.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

REFERENCE MATERIAL = Choosing a Hospital - #10181

SCRIPT = CC Inpatient Mental Health/Psychiatric Care

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

SKILLED NURSING FACILITY CARE

Medicare helps pay for skilled care in a skilled nursing facility (SNF). Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe and evaluate your care.

Examples of skilled care include changing sterile dressings and physical therapy. Care that can be given by non-professional staff is not considered skilled care.

Medicare does not pay for custodial or long-term care.

Medicare **will pay** for skilled care in a SNF if:

- You have Medicare Part A and have days left in your benefit period available to use.
- You have a qualifying hospital stay. This means an inpatient stay of three consecutive days or more, not including the day you leave the hospital.
- Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff.
- You get these services in a SNF that has been certified by Medicare.
- You need these skilled nursing services for a medical condition that was treated during a qualifying 3-day stay, or started while you were getting Medicare-covered SNF care.

A SNF could be part of a nursing facility or a hospital. Medicare certifies these facilities if they have the staff and

equipment to give skilled nursing and/or skilled rehabilitation services and other related health services.

Medicare will cover up to 100 days in a SNF for each benefit period. Medicare will pay the full cost for the first 20 days. For days 21-100 you will be responsible for a daily copayment of $124 ($119 in 2006). Beyond 100 days you will be responsible for the full cost.

Covered services include the following:

- Semi private room
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy
- Medical social services
- Medications
- Medical supplies & equipment used in a facility
- Dietary counseling

CSR Tips:

SCRIPT = EE Social Health Maintenance Organization SHMO and EE Program of All Inclusive Care for Elderly PACE for nursing home care alternatives.

TIP = If the beneficiary is not sure if a facility is a Medicare-certified Skilled Nursing Facility, they should call the facility's business office or check the Nursing Home Compare tool at www.medicare.gov. If they don't have access to the internet, transfer to an MBS who can use the CS Medicare.gov Tools script and then click on "Nursing Home Compare Overview."

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

WEB = Guide to Choosing a Nursing Home - #02174

WEB = Medicare Coverage of Skilled Nursing Facility Care - #10153

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER I

TIP = There are 11 Local Medical Review Policies (LMRPs) and 2 National Coverage Determinations (NCDs) written that explain when services or supplies are covered, including when they are considered medically necessary. For more information about LMRPs and NCDs for these services or supplies, please visit the Medicare Coverage Database on www.cms.hhs.gov.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

Drug Coverage LIS Extra Help Apply

START » **Use this script for information about the extra help.** (**If caller lives in one of the U.S. Territories, read script: Drug Coverage LIS Territories**)

If caller wants to know if they are eligible for the extra help and passes disclosure, **use the MA PDP tab** to provide information.

For help with the MA PDP tab, please review the **MA PDP Job Aid.**

» If the **Deemed Indicator = Y** or caller is LIS approved, **click here** to provide information based on the fields in the MA PDP tab.

» If the **Deemed Indicator = N**, caller is not LIS approved, or cannot pass disclosure, **click here** for income/ resource questions.

» If caller says they were approved for the extra help, but our system does not show it, **click here**.

» Click on one of the links below for information on the extra help:

HOW TO APPLY	**REAPPLYING**	**INCOME/RESOURCE LIMITS**
EXTRA HELP INFORMATION ISN'T CORRECT IN SYSTEM	**LETTER ABOUT LIS STATUS**	

DEEMED INDICATOR = Y OR CALLER IS LIS APPROVED

TOP BACK

Our records show that you qualify for extra help paying for Medicare prescription drug coverage. Most people who are eligible for this extra help will have reduced premiums, deductibles, and will pay no more than $5.35 ($5.00 in 2006) for each prescription. The amount of extra help depends on your income and resources. To get drug coverage, you will need to join a Medicare prescription drug plan. I can help you apply for a drug plan if you are in a valid enrollment period.

****CSR NOTE:** If caller wants information on their personal subsidy level, go to the MA PDP tab and check the Limited Income Subsidy History applet.**

****CSR NOTE: If caller wants to know if they will continue to be eligible for the extra help the following year, READ**:**
If you qualify for extra help during the current calendar year, each fall, the Centers for Medicare and Medicaid Services (CMS) will determine if you will continue to be eligible for the extra help for the following calendar year. If you became eligible for Medicaid from July to December, you will automatically be eligible for the extra help until the end of the year and in the following year.

TOP BACK

TIP BOX:

SCRIPT = CS Medicare.gov Tools

TOP BACK

HOW TO APPLY

TOP BACK

Most people who are eligible for this extra help will have reduced premiums, deductibles, and will pay no more than $5.35 ($5.00 in 2006) for each prescription. The amount of extra help depends on your income and resources.

You can apply for extra help at any time by filling out and mailing an application to the Social Security Administration (SSA). You can also apply online at www.ssa.gov.

CLICK HERE IF CALLER ASKS ABOUT APPLYING AT THE MEDICAID OFFICE

After you apply, you'll get a letter stating whether or not you qualify and what you need to do next. If you disagree with the decision, you have the right to appeal within 60 days from the date you received your letter. Contact the Social Security Administration to find out how to file the appeal.

When you are approved for the extra help, it will automatically be applied to your plan's costs starting on the day that your extra help became effective. You'll receive it for the duration of the year, as long as there are no changes to your status.

- If you are already in a drug plan, the extra help starts the first day of the month in which your application was received.
- If you are not already in a plan and you are auto-enrolled into a plan by Medicare, the enrollment will be retroactive to the date of your approval for the extra help.

This means that you can get reimbursed for any premiums and cost-sharing that you paid

retroactive to the date that the extra help started. You will need to contact the plan to find out how to be reimbursed.

If you're not in a plan, but you apply for extra help and are approved, you will get a special enrollment period to join a drug plan. (**SCRIPT, Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage**) If you were approved for the extra help AND joined a plan by December 31, 2007, you do not have to pay a late enrollment penalty.

Please contact SSA to:

- get help filling out an application.
- check the status of an application.
- appeal the decision.
- get a copy of your decision letter.
- ask any questions related to your decision letter.

ADDITIONAL INFORMATION:
You and your spouse can apply for the extra help on one application. However, when you join a drug plan, you will need to use separate applications.

If you apply at the Social Security Administration for the extra help and are approved, you will need to notify Social Security if your **marital status changes**. This includes marriage, divorce, annulment, permanent separation, death of a spouse, or if you resume living with your spouse after a separation. If this change causes you to lose your extra help, it will be effective the month after you report it.

If you apply at your local Medicaid office, your state may have rules that require you to report any status changes, such as a change in marital status. Please contact them for more information.

When applying for the extra help, you must submit an original application (not a photocopy).

The application will ask for your level of income and resources. You won't have to send any documents when you apply.

The Social Security Administration (SSA) does not accept applications by phone.

TOP BACK

TIP BOX:

REFERRAL = SSA
PRINT FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERENCE MATERIAL = SSA LIS Determination- Partial Subsidy
REFERENCE MATERIAL = SSA LIS Determination- Full Subsidy

TOP BACK

APPLYING AT MEDICAID

TOP BACK

Applying for extra help through SSA gives you the quickest decision, but you can also apply at your local Medicaid office. The state will then decide if you qualify for this help or other assistance that your state provides.

TIP BOX:

REFERRAL = Medicaid, if caller applied at the local Medicaid office.

TOP BACK

REAPPLYING FOR EXTRA HELP

TOP BACK

If you qualify for the extra help, you'll receive it for the duration of the year, as long as there are no changes to your status. Your eligibility will be reviewed each year and you'll be told if you qualify for extra help for the next year. If you do qualify, you won't need to reapply. However, if in any year you are told that you don't qualify and you do not agree, you will have to reapply.

If you applied at the Social Security Administration for the extra help and were approved, you will need to notify Social Security if your **marital status changes**. This includes marriage, divorce, annulment, permanent separation, death of a spouse, or if you resume living with your spouse after a separation. If this change causes you to lose your extra help, it will be effective the month after you report it.

If you applied at your local Medicaid office, your state may have rules that require you to report any status changes, such as a change in marital status. Please contact them for more information.

TIP BOX:

REFERENCE MATERIAL = SSA LIS Determination- Denial

TOP BACK

What best describes your situation? **Click the appropriate link.**

» **MARRIED AND LIVING TOGETHER**

» **SINGLE, A WIDOW(ER), OR YOUR SPOUSE DOES NOT LIVE WITH YOU**

TOP BACK

INCOME/RESOURCE LIMITS FOR PEOPLE WHO ARE MARRIED AND LIVING TOGETHER

TOP BACK

INCOME

If your annual income is below $20,535, you may qualify for the extra help. Even if your annual income is higher, you may still qualify. Some examples in which your income may be higher would be if you or your spouse:

- Support other family members who live with you.
- Have earnings from work.
- Live in Alaska or Hawaii.

The income amounts will increase each year. The income limits for 2006 were $19,800, if married.

RESOURCES

If your savings, investments, and real estate (other than your home) are worth less than $23,410 in 2007, you may qualify for the extra help. You should include the things you own by yourself, with your spouse, or with someone else. Do not include your home or personal possessions.

The resource levels will increase each year. The resource limits for 2006 were $23,000, if married.

» Does the caller have income/resources under these amounts?

Yes / **No**

TOP BACK

INCOME/RESOURCE LIMITS FOR PEOPLE WHO ARE SINGLE

TOP BACK

INCOME

If your annual income is below $15,315, you may qualify for the extra help. Even if your annual income is higher, you may still qualify. Some examples in which your income may be higher would be if you:

- Support other family members who live with you.
- Have earnings from work.
- Live in Alaska or Hawaii.

The income amounts will increase each year. The income limits for 2006 were $14,700, if single.

RESOURCES

If your savings, investments, and real estate (other than your home) are worth less than $11,710 in 2007, you may qualify for the extra help. You should include the things you own by yourself or with someone else. Do not include your home or personal possessions.

The resource levels will increase each year. The resource limits for 2006 were $11,500, if single.

» Does the caller have income/resources under these amounts?

Yes / **No**

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TOP BACK

Based on your answers, you may not qualify for extra help paying for Medicare prescription drug coverage. However, the only way to know for sure whether you qualify for extra help is to apply.

I would be happy to send you an application. You can also request one from the Social Security Administration (SSA) by calling them, visiting www.socialsecurity.gov on the web, or by visiting your local SSA office. Would you like me to send you an application today?

CLICK HERE IF CALLER WANTS HELP WITH FILLING OUT AN APPLICATION OR TO CHECK ON THE STATUS OF AN APPLICATION

TOP BACK

TIP BOX:

FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERRAL = Social Security Administration

TOP BACK

TOP BACK

Based on your answers, you MAY qualify for extra help paying for Medicare prescription drug coverage. However, the only way to know for sure whether you qualify for extra help is to apply.

I would be happy to send you an application. You can also request one from the Social Security Administration (SSA) by calling them, visiting www.socialsecurity.gov on the web, or by visiting your local SSA office. Would you like me to send you an application today?

CLICK HERE IF CALLER WANTS HELP WITH FILLING OUT AN APPLICATION OR TO CHECK ON THE STATUS OF AN APPLICATION

TOP BACK

TIP BOX:

FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERRAL = Social Security Administration

TOP BACK

CALLER IS APPROVED, BUT SYSTEM DOES NOT SHOW IT

Please keep a copy of your award letter. You may need to show it to your plan as proof that you qualify for extra help.

Medicare drug plans must use a "best available evidence" policy which requires plans to collect documentation confirming your extra help status. Medicare's system is updated at the beginning of each month.

If your drug plan wishes to verify your eligibility for the extra help, the plan may contact the State Medicaid Office or the Social Security Administration, depending on who approved your eligibility.

TIP BOX:

REFERRAL = Medicare drug plan

TOP BACK

EXTRA HELP INFORMATION ISN'T CORRECT IN SYSTEM

If the information the Centers for Medicare and Medicaid Services (CMS) has about your extra help status is incorrect, you should contact your Medicare drug plan. Medicare drug plans must use a "best available evidence" policy which requires plans to collect documentation confirming your extra help status. Medicare's system is updated at the beginning of each month.

If your drug plan wishes to verify your eligibility for the extra help, the plan may contact the State Medicaid Office or the Social Security Administration, depending on who approved your eligibility.

TIP BOX:

REFERRAL = Medicare drug plan

TOP BACK

LETTER ABOUT LIS STATUS

READ: Please look at the first page of your letter. Look for one of the following statements:

- **We must regularly review the cases of people who receive extra help with Medicare prescription drug plan costs**
  OR
- **We are changing the amount of the extra help you get with Medicare prescription drug plan costs**
  OR
- **Please keep this notice for your records**

TOP BACK

REDETERMINATION LETTER

TOP BACK

You received this letter because the Social Security Administration (SSA) needed to see how your income and financial status compared with the information on file. You had 15 days to submit a response to this letter. SSA then used this information to determine your eligibility for extra help for the following year.

****If the beneficiary responded and received a follow-up letter,** click here.

TOP BACK

TIP BOX:

REFERENCE MATERIAL = Drug Coverage Notice of Review Redetermination Letter

TOP BACK

SSA REEVALUATION LETTER

TOP BACK

You received this letter because you responded to a previous letter from the Social Security Administration. Your response contained updated information for your income and resources and was used to determine whether you qualify for the extra help in the coming year. Based on the updated information you provided, SSA reevaluated their determination for your extra help.

If the reevaluation resulted in losing the extra help or a change in copay, keep in mind that your costs will change. You get a special enrollment period to choose a different plan. It is very important that you choose a Medicare drug plan that meets your needs. You should see if the plan Medicare chose for you covers the drugs you use and if you can go to the pharmacies you prefer. The special enrollment period is January 1 through March 31 of each calendar year or begins the month in which you received your reevaluation notice and lasts up to 2 months after (whichever occurs later in the year).

****CSR NOTE:** If caller wants to know their copay level for 2007, use the MA PDP to provide the information.**

ADDITIONAL INFORMATION:
If you disagree with the reevaluation and would like to appeal the decision, you will have 60 days from the date of this letter to ask for an appeal. To file the appeal, you can contact the Social Security Administration at 1-800-772-1213 or you can download a copy of the form "Request for Appeal of Determination for Help with Medicare Prescription Drug Plan Costs" (SSA - 1021) from www.ssa.gov.

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TIP BOX:

REFERRAL = SSA

TOP BACK

REDEEMING NOTICE

TOP BACK

****CSR NOTE:** Some people received a "Loss of Status" redeeming notice but have since re-qualified for extra help. These people may not have been notified of their new status yet. Verify the caller's LIS status in NGD by going to the Deemed Reason Code in the Deemed Eligible History in the MA PDP tab.

READ: What does the letter say after "Please keep this notice for your records"?

If letter says "You are getting this notice because starting January 1, you will no longer automatically qualify for extra help", READ: You received this letter from Medicare because your income or resources changed. Effective January 1, you no longer automatically qualified for the extra help because you no longer:

- qualified for both Medicare and Medicaid; OR
- received help from your state paying for your Medicare premiums; OR
- received Supplemental Security Income (SSI) benefits.

You will continue to have coverage through your plan, as long as they still offer coverage in 2007. If you have questions about how your current coverage will be affected by this change, or you want to see what other options are available with the same company, you will need to call your plan.

The good news is you may still be able to save on your Medicare prescription drug coverage costs. You may still qualify by applying for extra help with the Social Security Administration or your State Medicaid Office.

Would you like information on reapplying for the extra help?

CLICK HERE IF CALLER WANTS TO REAPPLY

If letter says "You will continue to qualify for extra help to pay for Medicare prescription drug coverage next year", READ: You received this letter because your copay amount has changed. You still qualify for the extra help automatically for all of this year. Your old and new copay amounts are listed in the second paragraph of this letter.

TOP BACK

TIP BOX:

TIP = **CLICK HERE IF CALLER DOES NOT AGREE WITH LETTER (applies to both letters)**
TIP = If caller received the letter in English and would like it in Spanish, have them look for the publication number at the lower right-hand corner of the letter. GO TO Print Fulfillment to order a copy in Spanish.
REFERENCE MATERIAL = Redeeming Notice (Loss of Status)
REFERENCE MATERIAL = Redeeming Notice (Change in Copay)
FULFILLMENT = Redeeming Notice (Loss of Status) Spanish - 11198-S
FULFILLMENT = Redeeming Notice (Change in Copay) Spanish - 11199-S

REAPPLYING

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The easiest way to reapply is by filling out and mailing the application that was included with your letter from Medicare. If you have questions about filling out the application, please contact the Social Security Administration (SSA) at 1-800-772-1213 (TTY users should call 1-800-325-0778). You can also visit Social Security online at www.ssa.gov.

You can also reapply by:

- completing an application for the extra help online at www.ssa.gov;
- contacting SSA by phone;
- mailing in a paper application; OR
- visiting the local Social Security office.

Whatever method you choose, be sure to apply as soon as possible. There is no cost or obligation to apply.

Remember, you can always apply or reapply for extra help if your income and resources change. Would you like information on the income and resource limits for the extra help?

CLICK HERE IF CALLER WANTS INFORMATION ON INCOME/RESOURCE LIMITS

If caller asks, "What if I still don't qualify for extra help?" **CLICK HERE**

TOP BACK

TIP BOX:

REFERRAL = SSA
REFERRAL = State Medicaid Office

STILL DON'T QUALIFY

TOP BACK

If you don't qualify for extra help, there may be other options for lowering your prescription drug costs.

- Your state may have programs that provide help paying for your prescription drug costs. Please contact your State Medicaid Office for more information.
- Many of the major drug companies offer Pharmaceutical Assistance Programs (PAPs) for people with Medicare drug plans.
- You may be able to join a State Pharmacy Assistance Program (SPAP).

TOP BACK

TIP BOX:

REFERRAL = State Medicaid Office
SCRIPT = Drug Coverage Cost Information, if caller wants more information on costs and SPAPs or PAPs [Coverage Gap Donut Hole].
SCRIPT = Drug Coverage and Other Coverage, if caller wants more information on how SPAPs and PAPs work with Medicare drug coverage.

TOP BACK

DISAGREES WITH REDEEMING NOTICE

TOP BACK

__IF CALLER DISAGREES WITH COPAY AMOUNT__, confirm that the copay amount that the caller disagrees with matches the copay amount showing in NGD.

If you disagree with the decision in the letter you received, contact your State Medicaid Office.

****CSR NOTE:** If the caller complains about the copay increase (ex: $5 in 2006 vs $5.35 in 2007) but their subsidy level has not changed, use your soft skills to explain that there has been no change in their subsidy approval.**

__IF CALLER DISAGREES WITH LOSS OF LIS ELIGIBILITY__, continue with this portion. You can determine why the caller's LIS status changed by hovering over the Deemed Reason Code in the Deemed Eligible History in the MA PDP tab. A definition of the Deemed Reason Code will then appear.

If you disagree with the decision in the letter you received, contact your State Medicaid Office or the Social Security Administration to verify your eligibility for Medicaid or SSI benefits. If you received this letter because you:

- **no longer qualify for Medicaid,** please contact your State Medicaid Office.
- **no longer get help paying for your Medicare premiums,** please contact your State Medicaid Office.
- **no longer receive Supplemental Security Income (SSI),** please contact the Social

Security Administration at 1-800-772-1213.

TOP BACK

TIP BOX:

REFERRAL = State Medicaid Office
REFERRAL = SSA
SCRIPT = Drug Coverage Cost Information [LIS Cost], for LIS copay amounts for 2006 and 2007.

TOP BACK

HOSPICE CARE

Medicare helps pay for care from a Medicare-approved hospice program when you are terminally ill.

You can get hospice benefits when:

- You have Medicare Part A;
- Your doctor and the hospice medical director certify that you are terminally ill and have 6 months or less to live if the disease runs its normal course; and
- You sign a statement choosing hospice care instead of other Medicare-covered services for the terminal illness.

Hospice care for terminal and related conditions may include:

- Doctor and nursing services
- Medical equipment (such as wheelchairs)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control and pain relief
- Short-term care in the hospital (including respite care)
- Home health aide and homemaker services
- Physical, speech and occupational therapies

- Social worker services
- Dietary counseling
- Counseling to help you and your family with grief and loss

The Medicare hospice benefit is designed to allow you to remain in your home.

Medicare will not cover room and board if you chose to be in a hospice facility. However, room and board are covered if you require short term inpatient care in a hospital or a skilled nursing facility for pain and symptom management or for short term respite care.

HOSPICE PERIODS: Hospice care is given in periods. A period of care starts the day you begin to get hospice care. To start hospice care, your doctor and the hospice medical director must certify that you have a terminal illness with a prognosis of six months or less, if the disease runs its normal course, for the initial 90-day election period.

To continue hospice care, the hospice medical director must certify your terminal illness for the second 90-day election period and for each additional 60-day period.

Your hospice period of care will end if you are no longer determined to have a terminal illness, or when you revoke the hospice benefit.

You may revoke the hospice benefit at any time. In order to cancel the election, you must file a document with the hospice. You will then forfeit any remaining days in that election period, and your Medicare coverage will continue.

If you choose hospice care, Medicare may still pay for covered services that are not related to your terminal illness. Medicare will also pay all of your covered hospice services except for a co-payment of up to $5 for each outpatient prescription drug for pain relief and 5% of the Medicare payment amount for inpatient respite care.

When a person with Medicare enters hospice, generally his/her Part A benefit will cover all services and items for the hospice illness. Your hospice benefit will pay all charges from the hospice provider and other doctors, facilities, drugs (for symptom control and pain relief), medical services and supplies related to the hospice illness.

MEDICAL EQUIPMENT: Items and services not related to the hospice terminal condition are paid separately. This will include doctors, facilities and medical supplies that you may need for other medical conditions that are different from the hospice illness. This means that if you need durable medical equipment, you should still be able to receive the item under your Part B benefit as long as it is medically necessary. If your doctor gives you an order for medical supplies and the supplier is refusing to give you the item due to an open hospice segment, I can transfer you to a representative that will be able to assist you further.

****CSR NOTE: Probing Questions for Hospice DME:**

- When did you get the durable medical equipment?
- Is the durable medical equipment related to the treatment of the qualifying diagnosis for participation in hospice?
- Is this durable medical equipment that you continually received through DME benefits before you went into the hospice program?

****CSR NOTE:** If the person with Medicare wants to receive equipment and the provider is denying services due to a **non-related hospice illness,** transfer to a Tier II Claims CSR.

ADDITIONAL INFORMATION: You may receive hospice benefits through Original Medicare or through a Medicare Advantage Plan. Medicare Advantage Plans must provide the same hospice benefits as Original Medicare.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

SCRIPT = Drug Coverage Part A Part B Covered Drugs, for questions about drug coverage for those receiving hospice care.

TIP = Medicare covers a one-time evaluation consultation service for a beneficiary who has never elected the hospice benefit or does not wish to elect the hospice benefit. There is no co-pay requirement.

REFERRAL = Hospice Organization to help find a Medicare-approved Hospice Program.

SCRIPT = CC Respite Care in Hospice for information on relief for caretakers of Hospice patients.

WEB = www.nhpco.org (National Hospice & Palliative Care Organization) and http://www.nahc.org/haa/ (Hospice Association of America).

FULFILLMENT = Medicare Hospice Benefits - #02154

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER I

TIP = There are 9 Local Medical Review Policies (LMRPs) and 0 National Coverage Determinations (NCDs) written that explain when services or supplies are covered, including when they are considered medically necessary. For more information about LMRPs and NCDs for these services or supplies, please visit the Medicare Coverage Database on www.cms.hhs.gov.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

TOP BACK

PART A COVERAGE HOME HEALTH

You may get Medicare home health care benefits if you have either Medicare Part A or Part B.

To qualify you must meet the following conditions:

- Your doctor decides that you need **medical care at home** and will periodically review a plan for your care at home; and
- You need either intermittent skilled nursing care, or physical, speech, or occupational therapy; and
- You are homebound (normally unable to leave home); and
- The home health agency caring for you is approved by Medicare.

If you meet all these conditions, **Medicare will cover**:

- Intermittent or part-time **skilled nursing care-** services performed by a registered or licensed practical nurse.
- Intermittent **home health aide services** if you are also getting skilled care such as nursing care or therapy. Aides can assist with meal preparation, light housekeeping, laundry, bathing, and personal care.
- **Physical therapy** (exercise to regain movement), **speech therapy** (exercise to regain and strengthen speech skills) and **occupational therapy** (learn to do daily activities alone).
- **Medical social services** (help with community resources, social and emotional concerns and counseling).
- **Medical supplies** (e.g. wound dressings, **NOT drugs** except injectable osteoporosis drugs)
- **Durable medical equipment** (e.g. wheelchair, walker, commode, hospital bed).
- **Injectable osteoporosis drugs** for bone fractures related to post menopausal osteoporosis.

You **do not** have to pay a deductible or coinsurance for home health services. However, you will have to pay 20% of the Medicare- approved amount for durable medical equipment and for the covered osteoporosis drugs. Your Home Health agency is responsible for providing durable medical equipment while you are receiving services from them and they must arrange with the supplier to bill Medicare.

Care is usually provided through visits that last less than an hour or two.

CSR Tips:

WEB = Medicare and Home Health Care - #10969

REFERRAL = If caller is in a Medicare Advantage Plan, refer to the plan for coverage information.

TIP = If caller doesn't have Part B, they may be responsible for all costs of durable medical equipment.

TRANSFER = If caller wants help finding Home Health Agencies and comparing his/her quality of care, transfer to Medicare Benefits Specialists (MBS).

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER I

TIP = There are 4 Local Medical Review Policies (LMRPs) and 4 National Coverage Determinations (NCDs) written that explain when services or supplies are covered, including when they are considered medically necessary. For more information about LMRPs and NCDs for these services or supplies, please visit the Medicare Coverage Database on www.cms.hhs.gov.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

BENEFICIARY ACCESS TO RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION SERVICES (RNHCI)

Medicare pays for inpatient services in a Medicare-qualified Religious Nonmedical Health Care Institution. The RNHCI benefit is a Medicare option for those with religious beliefs that rely on a religious method of healing, instead of regular medical services. You have to pay for the religious part of the care.

To qualify for care in a Religious Nonmedical Health Care Institution:

- If not for your religious beliefs, you would require care in a conventional hospital or skilled nursing facility that is not a Religious Nonmedical Health Care Institution.
- If you are enrolled in a Medicare Advantage Plan, you must get pre-approval from the plan for a specific period before you are admitted to the RNHCI.
- If you do not get pre-approval, your stay may not be covered.
- If you need to stay in the RNHCI after the approved period, you must also get pre-approval for the additional days.

- If you or the RNHCI do not get pre-approval for the extra days, the extra days may not be covered by your plan.

If you have Original Medicare or a Medicare Advantage Plan, you must have a valid **election statement** on file in order for Medicare to pay for the RNHCI service. The RNHCI election statement is a written statement prepared by the RNHCI at the time of admission that confirms the following:

- You are conscientiously opposed to getting medical treatment.
- Accepting medical treatment is against your sincere religious beliefs.
- You agree that voluntarily getting medical treatment will cancel the election. It may also mean that you may have a long wait before being qualified to receive services in a RNHCI.
- You understand that the election may be cancelled at any time by sending a written statement to Medicare.
- You understand that neither the presence nor cancellation of the election will stop you from getting Medicare Part A covered medical services in other types of facilities.

For each benefit period you pay:

- Day 1 - 60: $992 deductible
- Day 61 - 90: $248 each day
- Days 91 - 150: $496 each day
- Beyond day 150: all costs

CSR Tips:

REFERRAL = The Medicare contractor for RNHCI services is Blue Cross and Blue Shield of TN (**Contractor ID 00390**), if the caller has additional questions.

TIP = There is no standard government form for an election statement.

TIP = **Excepted** medical treatment is received involuntarily or is required by law. It could include vaccinations, immediate care following an accident, or care while unconscious.

TIP = An example of **nonexcepted** medical care is a person in a RNHCI who is transferred to a community hospital to have diagnostic x-rays of a suspected arm fracture.

TIP = Medicare does not pay for supporting religious services or services by a religious practitioner.

TOP **BACK**

CUSTODIAL CARE, ASSISTED LIVING, ADULT DAYCARE AND REIMBURSEMENT FOR FAMILY MEMBERS

Custodial Care:

Medicare does not cover custodial care. Most nursing home care is custodial care such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Assisted Living:

Medicare Part B does not cover skilled nursing care given in an assisted living facility.

Medicare Part A only covers skilled care given in a certified skilled nursing facility. You must meet certain medical conditions and coverage is limited. If you are not sure if a facility participates in Medicare as a skilled nursing facility, you should ask someone in the facility's business office.

Adult Daycare:

Adult Daycare is not a covered benefit under the Medicare Program.

Reimbursement for Family Members:

Medicare does not reimburse a beneficiary's family member for in-home care.

Medicare may help pay for care in the home by a home health agency that participates with Medicare.

****CSR NOTE:** If caller wants to go over home health coverage options transfer to a Tier II.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

SCRIPT = See Medicaid information in the script, "EE Social Health Maintenance Organization SHMO" and "EE Program of All Inclusive Care for Elderly PACE" for choices on nursing home care.

WEB = www.benefitscheckup.org

WEB = Your Guide To Choosing a Nursing Home - #02174

WEB = Medicare & Home Health Care - #10969

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

RESPITE CARE IN HOSPICE

Medicare pays for respite care. As a hospice patient, you may have one person that takes care of you everyday.

Sometimes they need someone else to take care of you for a short period while they do other things that need to be done.

Respite care is care given to a hospice patient by another caregiver so that the usual caregiver can rest.

During a period of respite care, which may be up to 5 days, you will be cared for in a Medicare- approved facility, such as a hospice facility, hospital or nursing home.

When receiving these services you would pay up to a $5 co-payment for each prescription for outpatient drugs and 5% of the Medicare-approved amount for inpatient respite care.

CSR Tips:

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

INPATIENT MENTAL HEALTH / PSYCHIATRIC CARE

Medicare helps pay for inpatient mental health care.

Mental health care includes services and programs to help find, diagnose and treat mental health problems. These services can be given in a general hospital or in a specialty psychiatric hospital that only cares for people with mental health problems.

Regardless of which type of hospital you choose, Medicare Part A helps pay for mental health services the same way it does for any other Medicare inpatient hospital care.

If you are in a specialty psychiatric hospital, Medicare Part A helps pay up to 190 days of inpatient care in a Medicare-certified psychiatric facility during your lifetime.

There is **no lifetime limit** on inpatient care given in general hospitals. You may get care in general hospitals after you reach the 190 day lifetime limit in specialty psychiatric hospitals.

In 2007, the amounts you pay for each benefit period will be:

- A total of $992 ($952 in 2006) for a hospital stay of 1-60 days
- $248 ($238 in 2006) per day for days 61-90 of a hospital stay
- $496 ($476 in 2006) per day for days 91-150 of a hospital stay (lifetime reserve days)
- All costs for each day beyond 150 days

Medicare does not cover the cost of private duty nursing, a telephone or television in your room, or a private room unless medically necessary.

There is no extra cost for using your lifetime psychiatric days. The same Part A inpatient costs including your deductible and coinsurance will apply.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

WEB = Medicare and Your Mental Health Benefits - #10184

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER I

TIP= There are 2 Local Medical Review Policies (LMRPs) and 0 National Coverage Determinations (NCDs) written that explain when services or supplies are covered, including when they are considered medically necessary. For more information about LMRPs and NCDs for these services or supplies, please visit the Medicare Coverage Database on www.cms.hhs.gov.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

TOP **BACK**

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INPATIENT ALCOHOL OR SUBSTANCE ABUSE TREATMENT

Medicare helps pay for inpatient and outpatient treatment of alcohol or substance abuse rehabilitation under the mental health care benefit.

Medicare coverage is based on your condition and past therapy or rehabilitation for drug or alcohol use. Your doctor can help determine if such a program is appropriate for you.

****CSR NOTE:** For additional **outpatient coverage** information see **SCRIPT** = CC Part B Covered/Noncovered Services, and click on "Outpatient Mental Health and Psychiatric Services."

For additional **inpatient coverage** information see **SCRIPT** = CC Inpatient Mental Health/Psychiatric Care.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

REFERRAL = The National Drug and Alcohol Treatment Referral Routing Service at 1-800-662-HELP, offers other information. Through this service you can speak directly to a representative about substance abuse treatment, request printed material, or obtain local substance abuse treatment referral information in your State.

WEB = Substance Abuse Treatment Facility Locator at: www.findtreatment.samhsa.gov

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

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PART A BLOOD

Medicare will help with the cost of blood if you need it as part of your Medicare-covered stay in a hospital or a skilled nursing facility.

This includes whole blood, units of packed red blood cells or blood components. If you receive blood, you must either pay for or replace the first three pints of blood each year, which is the annual blood deductible.

You can replace the blood yourself or have another person donate it on your behalf.

CSR Tips:

SCRIPT = CC Prior Determination of Medicare Coverage FFS Referral if services, supplies or equipment have not yet been given and caller wants to confirm that they are covered.

SCRIPT = CC Accepting Assignment vs. Not Accepting Assignment

TRANSFER = PART A Claims CSR if caller has questions about items or services provided in a hospital or other facility, doctor or outpatient services, supplies, services performed by a home health agency or hospice that cannot be answered with scripting.

PART A CLAIMS TIER I

TIP = There are 0 Local Medical Review Policies (LMRPs) and 3 National Coverage Determinations (NCDs) written that explain when services or supplies are covered, including when they are considered medically necessary. For more information about LMRPs and NCDs for these services or supplies, please visit the Medicare Coverage Database on www.cms.hhs.gov.

PART A CLAIMS TIER II

TRANSFER OF OWNERSHIP = Local Contractors for complex inquiries. Link to Complex Inquiries NOP

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CC PRIOR DETERMINATION OF MEDICARE COVERAGE FFS REFERRAL

- I am able to give you general Medicare coverage information.
- Medicare does not pre-authorize coverage for medical services.
- Medicare will make a coverage decision when your health care provider sends a claim to Medicare.
- Your health care provider should explain to you if Medicare typically covers the services s/he recommends for you.

****If a provider told the caller to get authorization:**
If the caller states that his or her provider told him or her to call Medicare to get pre-authorization, tell the caller to advise his or her provider that Medicare does not pre-authorize coverage for medical services.

****CSR NOTE:** If the beneficiary provides a procedure code and wants to know how much Medicare would pay, **READ**: The claim must be submitted in order for Medicare to determine coverage and payment.

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MEDICALLY NECESSARY

Services or supplies that:

- are proper and needed for diagnosis, or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

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MEDICARE - APPROVED AMOUNT

In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

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LIFETIME RESERVE DAYS

Medicare will pay part of the costs of inpatient hospital care for up to 90 days in a benefit period. After that time, you will have to pay all costs unless you use your reserve days. You have 60 reserve days that can be used if your hospital stay exceeds 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance of $496 for 2007 ($476 for 2006).

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BENEFIT PERIOD

Medicare uses a period of time called a Benefit Period to keep track of how many days of inpatient hospital care and Skilled Nursing Facility (SNF) benefits you use. A benefit period begins the day you go to a hospital or SNF. It ends when you have been out of the hospital or SNF for 60 days in a row. There is no limit to the number of benefit periods you have. You must pay the inpatient deductible and coinsurance for each benefit period.

Medicare will cover up to 100 days in a SNF in a benefit period. For the first 20 days, Medicare pays the full cost. For days 21 through 100 Medicare pays all but the daily coinsurance.

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CRITICAL ACCESS HOSPITAL

A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

TOP BACK

LONG - TERM CARE

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

TOP **BACK**

LIGHT HOUSEKEEPING

When a home health aide visits to provide a health related services, the home health aide may also perform some incidental services which do not meet the definition of a home health service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.).

TOP BACK

CS Ordering Replacement Medicare Card

SHORTCUT: If you have already ordered a replacement card, CLICK HERE for closing language.

Do you receive benefits from RRB or SSA?

SSA	**RRB**

CSR NOTE: Select SSA for beneficiaries who receive benefits from a civil service annuity check.**

CSR Tips

CALLER HAS RRB BENEFITS

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If the caller receives benefits from the RRB read:
With your permission, I will need to ask you a few questions in order to complete your request.

Also, I must inform you that the Railroad Retirement Board and Medicare are allowed to collect this information under the Privacy Act of 1974. The information is needed to quickly identify you and prepare the replacement Medicare card you requested. Giving us this information is voluntary. However, without this information, I will not be able to help you get a replacement Medicare card and you would need to contact the Railroad Retirement Board. To complete your request, I will need the following information:

1. Your name as it appears on your most recent Social Security card
2. Your RRB claim number (the retiree employee number)
3. Your Social Security number (the number of the person who needs the replacement card)
4. Your email address
5. Your mailing address
6. Your daytime phone number in case we need to contact you about your request

Do you have this information available?

YES	NO

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Click this link to complete the process: Order Medicare Card.

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Please contact the Railroad Retirement Board (RRB) at 1-800-808-0772. The hours of operation are 9:00 a.m. - 3:30 p. m. in your local time.

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CALLER HAS SSA BENEFITS

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I can help you order your replacement card and temporary statement of Medicare coverage.

CSR NOTE: Anyone calling on behalf of a beneficiary who can pass disclosure may order a replacement card because the replacement card goes to the beneficiary's address or the address on file. **Make sure that the caller passes disclosure using the following 4 pieces of disclosure:

1. HICN
2. Full Name
3. Address
4. Date of Birth

If NGD is down, CLICK HERE to complete the order.

To order the replacement Medicare card and temporary statement of Medicare eligibility:

1. Start on the BCC Tier I tab.
2. Select the "Order Medicare Card" button at the top of the Beneficiary applet.

After completing the order, CLICK HERE.

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NGD ORDERS, READ:
Thank you. Your order has been placed. You should receive a temporary statement of Medicare eligibility in about ten days and your new Medicare card in about four weeks.

****CSR NOTE:** If you received a message that the card will be ordered when the system is available, you can still tell the caller the card and temporary statement have been ordered.****

If the caller has ordered only a temporary statement of Medicare eligibility, READ:
Thank you. Your order has been placed. You should receive your temporary statement of Medicare eligibility in about ten days.

SSA WEBSITE ORDERS, READ:
Thank you. Your order has been placed. You should receive your new Medicare card in about 4 weeks.

If a temporary statement was also ordered, **READ:
You should receive a temporary statement of Medicare eligibility in about ten days.

****CSR NOTE**: If the caller lives in Puerto Rico, they should receive a new Medicare card within 12 weeks.****

If the caller needs immediate proof of Medicare eligibility and cannot wait ten days, READ:
If you need immediate proof of Medicare eligibility, visit your local Social Security office. The local office will be able to provide you with a temporary statement.

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I can help you apply for a replacement Medicare card online through Social Security's website at http://www.socialsecurity.gov.

Medicare and Social Security are allowed to collect information under the Privacy Act. We need this information to quickly identify you so you can receive your replacement Medicare card. Giving us this information is voluntary, and it will not be used by Medicare or Social Security for any other purpose. However, without this information we will not be able to help you get a replacement Medicare card and you will then need to contact Social Security directly. Social Security's phone number is 1-800-772-1213.

With your permission, I will need the following information in order to complete your request:

- Your Social Security number
- Your first name
- Your middle initial
- Your last name
- A suffix (Jr., Sr., II, etc.) if applicable
- Other last name if applicable
- Your date of birth

Order the Medicare card on SSA.gov: Click here for the SSA website.

After completing the order online, CLICK HERE.

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TIP BOX

TOP BACK

TIP = The beneficiary does not need to be present to order a replacement Medicare card.

TIP = The Medicare card may be laminated after being signed.

TIP = A temporary statement of Medicare coverage may also be referred to as an entitlement letter.

REFERRAL = The beneficiary may also apply for a replacement card online through Social Security's website at http://www.socialsecurity.gov or by calling SSA at 1-800-772-1213.

SCRIPT = EE Medicare Card Description

TOP BACK

Drug Coverage LIS Extra Help Apply

START » **Use this script for information about the extra help.** (**If caller lives in one of the U.S. Territories, read script: Drug Coverage LIS Territories**)

If caller wants to know if they are eligible for the extra help and passes disclosure, **use the MA PDP tab** to provide information.

For help with the MA PDP tab, please review the **MA PDP Job Aid.**

» If the **Deemed Indicator = Y** or caller is LIS approved, **click here** to provide information based on the fields in the MA PDP tab.

» If the **Deemed Indicator = N**, caller is not LIS approved, or cannot pass disclosure, **click here** for income/ resource questions.

» If caller says they were approved for the extra help, but our system does not show it, **click here**.

» Click on one of the links below for information on the extra help:

HOW TO APPLY	**REAPPLYING**	**INCOME/RESOURCE LIMITS**
EXTRA HELP INFORMATION ISN'T CORRECT IN SYSTEM	**LETTER ABOUT LIS STATUS**	

DEEMED INDICATOR = Y OR CALLER IS LIS APPROVED

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Our records show that you qualify for extra help paying for Medicare prescription drug coverage. Most people who are eligible for this extra help will have reduced premiums, deductibles, and will pay no more than $5.35 ($5.00 in 2006) for each prescription. The amount of extra help depends on your income and resources. To get drug coverage, you will need to join a Medicare prescription drug plan. I can help you apply for a drug plan if you are in a valid enrollment period.

****CSR NOTE:** If caller wants information on their personal subsidy level, go to the MA PDP tab and check the Limited Income Subsidy History applet.**

****CSR NOTE: If caller wants to know if they will continue to be eligible for the extra help the following year, READ**:**
If you qualify for extra help during the current calendar year, each fall, the Centers for Medicare and Medicaid Services (CMS) will determine if you will continue to be eligible for the extra help for the following calendar year. If you became eligible for Medicaid from July to December, you will automatically be eligible for the extra help until the end of the year and in the following year.

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TIP BOX:

SCRIPT = CS Medicare.gov Tools

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HOW TO APPLY

TOP BACK

Most people who are eligible for this extra help will have reduced premiums, deductibles, and will pay no more than $5.35 ($5.00 in 2006) for each prescription. The amount of extra help depends on your income and resources.

You can apply for extra help at any time by filling out and mailing an application to the Social Security Administration (SSA). You can also apply online at www.ssa.gov.

CLICK HERE IF CALLER ASKS ABOUT APPLYING AT THE MEDICAID OFFICE

After you apply, you'll get a letter stating whether or not you qualify and what you need to do next. If you disagree with the decision, you have the right to appeal within 60 days from the date you received your letter. Contact the Social Security Administration to find out how to file the appeal.

When you are approved for the extra help, it will automatically be applied to your plan's costs starting on the day that your extra help became effective. You'll receive it for the duration of the year, as long as there are no changes to your status.

- If you are already in a drug plan, the extra help starts the first day of the month in which your application was received.
- If you are not already in a plan and you are auto-enrolled into a plan by Medicare, the enrollment will be retroactive to the date of your approval for the extra help.

This means that you can get reimbursed for any premiums and cost-sharing that you paid

retroactive to the date that the extra help started. You will need to contact the plan to find out how to be reimbursed.

If you're not in a plan, but you apply for extra help and are approved, you will get a special enrollment period to join a drug plan. (**SCRIPT, Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage**) If you were approved for the extra help AND joined a plan by December 31, 2007, you do not have to pay a late enrollment penalty.

Please contact SSA to:

- get help filling out an application.
- check the status of an application.
- appeal the decision.
- get a copy of your decision letter.
- ask any questions related to your decision letter.

ADDITIONAL INFORMATION:
You and your spouse can apply for the extra help on one application. However, when you join a drug plan, you will need to use separate applications.

If you apply at the Social Security Administration for the extra help and are approved, you will need to notify Social Security if your **marital status changes**. This includes marriage, divorce, annulment, permanent separation, death of a spouse, or if you resume living with your spouse after a separation. If this change causes you to lose your extra help, it will be effective the month after you report it.

If you apply at your local Medicaid office, your state may have rules that require you to report any status changes, such as a change in marital status. Please contact them for more information.

When applying for the extra help, you must submit an original application (not a photocopy).

The application will ask for your level of income and resources. You won't have to send any documents when you apply.

The Social Security Administration (SSA) does not accept applications by phone.

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TIP BOX:

REFERRAL = SSA
PRINT FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERENCE MATERIAL = SSA LIS Determination- Partial Subsidy
REFERENCE MATERIAL = SSA LIS Determination- Full Subsidy

TOP BACK

APPLYING AT MEDICAID

TOP BACK

Applying for extra help through SSA gives you the quickest decision, but you can also apply at your local Medicaid office. The state will then decide if you qualify for this help or other assistance that your state provides.

TIP BOX:

REFERRAL = Medicaid, if caller applied at the local Medicaid office.

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REAPPLYING FOR EXTRA HELP

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If you qualify for the extra help, you'll receive it for the duration of the year, as long as there are no changes to your status. Your eligibility will be reviewed each year and you'll be told if you qualify for extra help for the next year. If you do qualify, you won't need to reapply. However, if in any year you are told that you don't qualify and you do not agree, you will have to reapply.

If you applied at the Social Security Administration for the extra help and were approved, you will need to notify Social Security if your **marital status changes**. This includes marriage, divorce, annulment, permanent separation, death of a spouse, or if you resume living with your spouse after a separation. If this change causes you to lose your extra help, it will be effective the month after you report it.

If you applied at your local Medicaid office, your state may have rules that require you to report any status changes, such as a change in marital status. Please contact them for more information.

TIP BOX:

REFERENCE MATERIAL = SSA LIS Determination- Denial

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What best describes your situation? **Click the appropriate link.**

» **MARRIED AND LIVING TOGETHER**

» **SINGLE, A WIDOW(ER), OR YOUR SPOUSE DOES NOT LIVE WITH YOU**

TOP BACK

INCOME/RESOURCE LIMITS FOR PEOPLE WHO ARE MARRIED AND LIVING TOGETHER

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INCOME

If your annual income is below $20,535, you may qualify for the extra help. Even if your annual income is higher, you may still qualify. Some examples in which your income may be higher would be if you or your spouse:

- Support other family members who live with you.
- Have earnings from work.
- Live in Alaska or Hawaii.

The income amounts will increase each year. The income limits for 2006 were $19,800, if married.

RESOURCES

If your savings, investments, and real estate (other than your home) are worth less than $23,410 in 2007, you may qualify for the extra help. You should include the things you own by yourself, with your spouse, or with someone else. Do not include your home or personal possessions.

The resource levels will increase each year. The resource limits for 2006 were $23,000, if married.

» Does the caller have income/resources under these amounts?

Yes / **No**

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INCOME/RESOURCE LIMITS FOR PEOPLE WHO ARE SINGLE

TOP BACK

INCOME

If your annual income is below $15,315, you may qualify for the extra help. Even if your annual income is higher, you may still qualify. Some examples in which your income may be higher would be if you:

- Support other family members who live with you.
- Have earnings from work.
- Live in Alaska or Hawaii.

The income amounts will increase each year. The income limits for 2006 were $14,700, if single.

RESOURCES

If your savings, investments, and real estate (other than your home) are worth less than $11,710 in 2007, you may qualify for the extra help. You should include the things you own by yourself or with someone else. Do not include your home or personal possessions.

The resource levels will increase each year. The resource limits for 2006 were $11,500, if single.

» Does the caller have income/resources under these amounts?

Yes / **No**

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Based on your answers, you may not qualify for extra help paying for Medicare prescription drug coverage. However, the only way to know for sure whether you qualify for extra help is to apply.

I would be happy to send you an application. You can also request one from the Social Security Administration (SSA) by calling them, visiting www.socialsecurity.gov on the web, or by visiting your local SSA office. Would you like me to send you an application today?

CLICK HERE IF CALLER WANTS HELP WITH FILLING OUT AN APPLICATION OR TO CHECK ON THE STATUS OF AN APPLICATION

TOP BACK

TIP BOX:

FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERRAL = Social Security Administration

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TOP BACK

Based on your answers, you MAY qualify for extra help paying for Medicare prescription drug coverage. However, the only way to know for sure whether you qualify for extra help is to apply.

I would be happy to send you an application. You can also request one from the Social Security Administration (SSA) by calling them, visiting www.socialsecurity.gov on the web, or by visiting your local SSA office. Would you like me to send you an application today?

CLICK HERE IF CALLER WANTS HELP WITH FILLING OUT AN APPLICATION OR TO CHECK ON THE STATUS OF AN APPLICATION

TOP BACK

TIP BOX:

FULFILLMENT = SSA Low Income Subsidy Application - 21020 **(Do NOT send to residents of U.S. Territories)**
REFERRAL = Social Security Administration

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CALLER IS APPROVED, BUT SYSTEM DOES NOT SHOW IT

Please keep a copy of your award letter. You may need to show it to your plan as proof that you qualify for extra help.

Medicare drug plans must use a "best available evidence" policy which requires plans to collect documentation confirming your extra help status. Medicare's system is updated at the beginning of each month.

If your drug plan wishes to verify your eligibility for the extra help, the plan may contact the State Medicaid Office or the Social Security Administration, depending on who approved your eligibility.

TIP BOX:

REFERRAL = Medicare drug plan

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EXTRA HELP INFORMATION ISN'T CORRECT IN SYSTEM

If the information the Centers for Medicare and Medicaid Services (CMS) has about your extra help status is incorrect, you should contact your Medicare drug plan. Medicare drug plans must use a "best available evidence" policy which requires plans to collect documentation confirming your extra help status. Medicare's system is updated at the beginning of each month.

If your drug plan wishes to verify your eligibility for the extra help, the plan may contact the State Medicaid Office or the Social Security Administration, depending on who approved your eligibility.

TIP BOX:

REFERRAL = Medicare drug plan

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LETTER ABOUT LIS STATUS

READ: Please look at the first page of your letter. Look for one of the following statements:

- **We must regularly review the cases of people who receive extra help with Medicare prescription drug plan costs**
  OR
- **We are changing the amount of the extra help you get with Medicare prescription drug plan costs**
  OR
- **Please keep this notice for your records**

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REDETERMINATION LETTER

TOP BACK

You received this letter because the Social Security Administration (SSA) needed to see how your income and financial status compared with the information on file. You had 15 days to submit a response to this letter. SSA then used this information to determine your eligibility for extra help for the following year.

****If the beneficiary responded and received a follow-up letter,** click here.

TOP BACK

TIP BOX:

REFERENCE MATERIAL = Drug Coverage Notice of Review Redetermination Letter

TOP BACK

SSA REEVALUATION LETTER

TOP BACK

You received this letter because you responded to a previous letter from the Social Security Administration. Your response contained updated information for your income and resources and was used to determine whether you qualify for the extra help in the coming year. Based on the updated information you provided, SSA reevaluated their determination for your extra help.

If the reevaluation resulted in losing the extra help or a change in copay, keep in mind that your costs will change. You get a special enrollment period to choose a different plan. It is very important that you choose a Medicare drug plan that meets your needs. You should see if the plan Medicare chose for you covers the drugs you use and if you can go to the pharmacies you prefer. The special enrollment period is January 1 through March 31 of each calendar year or begins the month in which you received your reevaluation notice and lasts up to 2 months after (whichever occurs later in the year).

****CSR NOTE:** If caller wants to know their copay level for 2007, use the MA PDP to provide the information.**

ADDITIONAL INFORMATION:
If you disagree with the reevaluation and would like to appeal the decision, you will have 60 days from the date of this letter to ask for an appeal. To file the appeal, you can contact the Social Security Administration at 1-800-772-1213 or you can download a copy of the form "Request for Appeal of Determination for Help with Medicare Prescription Drug Plan Costs" (SSA - 1021) from www.ssa.gov.

TOP BACK

TIP BOX:

REFERRAL = SSA

TOP BACK

REDEEMING NOTICE

TOP BACK

****CSR NOTE:** Some people received a "Loss of Status" redeeming notice but have since re-qualified for extra help. These people may not have been notified of their new status yet. Verify the caller's LIS status in NGD by going to the Deemed Reason Code in the Deemed Eligible History in the MA PDP tab.

READ: What does the letter say after "Please keep this notice for your records"?

If letter says "You are getting this notice because starting January 1, you will no longer automatically qualify for extra help", READ: You received this letter from Medicare because your income or resources changed. Effective January 1, you no longer automatically qualified for the extra help because you no longer:

- qualified for both Medicare and Medicaid; OR
- received help from your state paying for your Medicare premiums; OR
- received Supplemental Security Income (SSI) benefits.

You will continue to have coverage through your plan, as long as they still offer coverage in 2007. If you have questions about how your current coverage will be affected by this change, or you want to see what other options are available with the same company, you will need to call your plan.

The good news is you may still be able to save on your Medicare prescription drug coverage costs. You may still qualify by applying for extra help with the Social Security Administration or your State Medicaid Office.

Would you like information on reapplying for the extra help?

CLICK HERE IF CALLER WANTS TO REAPPLY

If letter says "You will continue to qualify for extra help to pay for Medicare prescription drug coverage next year", READ: You received this letter because your copay amount has changed. You still qualify for the extra help automatically for all of this year. Your old and new copay amounts are listed in the second paragraph of this letter.

TOP BACK

TIP BOX:

TIP = **CLICK HERE IF CALLER DOES NOT AGREE WITH LETTER (applies to both letters)**
TIP = If caller received the letter in English and would like it in Spanish, have them look for the publication number at the lower right-hand corner of the letter. GO TO Print Fulfillment to order a copy in Spanish.
REFERENCE MATERIAL = Redeeming Notice (Loss of Status)
REFERENCE MATERIAL = Redeeming Notice (Change in Copay)
FULFILLMENT = Redeeming Notice (Loss of Status) Spanish - 11198-S
FULFILLMENT = Redeeming Notice (Change in Copay) Spanish - 11199-S

REAPPLYING

TOP BACK

The easiest way to reapply is by filling out and mailing the application that was included with your letter from Medicare. If you have questions about filling out the application, please contact the Social Security Administration (SSA) at 1-800-772-1213 (TTY users should call 1-800-325-0778). You can also visit Social Security online at www.ssa.gov.

You can also reapply by:

- completing an application for the extra help online at www.ssa.gov;
- contacting SSA by phone;
- mailing in a paper application; OR
- visiting the local Social Security office.

Whatever method you choose, be sure to apply as soon as possible. There is no cost or obligation to apply.

Remember, you can always apply or reapply for extra help if your income and resources change. Would you like information on the income and resource limits for the extra help?

CLICK HERE IF CALLER WANTS INFORMATION ON INCOME/RESOURCE LIMITS

If caller asks, "What if I still don't qualify for extra help?" **CLICK HERE**

TOP BACK

TIP BOX:

REFERRAL = SSA
REFERRAL = State Medicaid Office

STILL DON'T QUALIFY

TOP BACK

If you don't qualify for extra help, there may be other options for lowering your prescription drug costs.

- Your state may have programs that provide help paying for your prescription drug costs. Please contact your State Medicaid Office for more information.
- Many of the major drug companies offer Pharmaceutical Assistance Programs (PAPs) for people with Medicare drug plans.
- You may be able to join a State Pharmacy Assistance Program (SPAP).

TOP BACK

TIP BOX:

REFERRAL = State Medicaid Office
SCRIPT = Drug Coverage Cost Information, if caller wants more information on costs and SPAPs or PAPs [Coverage Gap Donut Hole].
SCRIPT = Drug Coverage and Other Coverage, if caller wants more information on how SPAPs and PAPs work with Medicare drug coverage.

TOP BACK

DISAGREES WITH REDEEMING NOTICE

TOP BACK

__IF CALLER DISAGREES WITH COPAY AMOUNT__, confirm that the copay amount that the caller disagrees with matches the copay amount showing in NGD.

If you disagree with the decision in the letter you received, contact your State Medicaid Office.

****CSR NOTE:** If the caller complains about the copay increase (ex: $5 in 2006 vs $5.35 in 2007) but their subsidy level has not changed, use your soft skills to explain that there has been no change in their subsidy approval.**

__IF CALLER DISAGREES WITH LOSS OF LIS ELIGIBILITY__, continue with this portion. You can determine why the caller's LIS status changed by hovering over the Deemed Reason Code in the Deemed Eligible History in the MA PDP tab. A definition of the Deemed Reason Code will then appear.

If you disagree with the decision in the letter you received, contact your State Medicaid Office or the Social Security Administration to verify your eligibility for Medicaid or SSI benefits. If you received this letter because you:

- **no longer qualify for Medicaid,** please contact your State Medicaid Office.
- **no longer get help paying for your Medicare premiums,** please contact your State Medicaid Office.
- **no longer receive Supplemental Security Income (SSI),** please contact the Social

Security Administration at 1-800-772-1213.

TOP BACK

TIP BOX:

REFERRAL = State Medicaid Office
REFERRAL = SSA
SCRIPT = Drug Coverage Cost Information [LIS Cost], for LIS copay amounts for 2006 and 2007.

TOP BACK

Drug Coverage Cost Information

START » **Use this script for information about drug coverage costs.**

» Click on one of the links below for information on drug coverage costs:

COST	**LIS COST**	**COVERAGE GAP DONUT HOLE**
LATE ENROLLMENT PENALTY	**OUT OF POCKET TROOP**	**HOW TO PAY YOUR PREMIUMS**
	DELAY IN PREMIUM PAYMENT	

2007 COST

TOP BACK

****Use this section ONLY if caller does not have LIS.****

Medicare drug plans vary. This means that monthly premiums, deductibles, copayments, and formularies differ depending on the plan. Your costs also depend on which drugs you use and if you get extra help. **Costs vary from year to year and start over each calendar year (January - December).** This means that you will have to meet the deductible each year and your premiums, deductibles, and copays may change.

Plans must offer coverage that is as good as the Medicare minimum standard coverage.

****CSR NOTE:** If caller wants to know about the costs in 2008, **click here**.

2007 Medicare minimum standard coverage (this is an example, but stress that all plans vary):
When you join, you'll pay a monthly premium in addition to other Medicare premiums you pay now. The 2007 average premium is about $27.35, but premiums may be higher or lower. You may be able to get a plan without a monthly premium, deductible or coverage gap.

For a minimum standard plan, you pay the first $265 for your drugs. This is called your DEDUCTIBLE. This amount may vary for other types of plans.

After you pay the yearly deductible, here's how the costs work in 2007:

- You pay 25% of your yearly drug costs, from $265 to $2,400, and your plan pays the other 75% of these costs. This means you pay $533.75 out-of-pocket for this phase of the benefit. This period is called the INITIAL COVERAGE LEVEL. Keep in mind that the costs until the end of the initial coverage level ($2,400) are based on the full cost of the drugs, not what you pay.

- You pay 100% of the next $3051.25 in drug costs until you have $3,850 in out-of-pocket costs. This amount is called the COVERAGE GAP. (CSR NOTE: $265 deductible + $533.75 (25% share of $265 to $2400) + $3051.25 = $3850 out-of-pocket cost.)
- After you have spent $3,850 out-of-pocket, you pay 5% of your drug costs (or a small copayment) for the rest of the calendar year and your plan pays the rest. This is called CATASTROPHIC COVERAGE.

Some plans may have a different structure, including a set copayment amount (specific dollar amount) instead of a coinsurance (a percentage of the drug cost), different limits on the initial coverage level and coverage gap. Payments made for monthly premiums or toward drugs not covered by the plan (due to not being on the formulary or being excluded by Medicare Law) will not count toward your deductible, initial coverage level, or catastrophic coverage.

****CSR NOTE:** Use the CSR Plan Finder Tool for cost information on each plan.**

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TIP BOX:

SCRIPT = Coverage Gap Donut Hole
REFERRAL = Medicare prescription drug plan, if caller feels that they are being charged the wrong copayment amount or they have any other cost-related questions about their plan. You can also refer to the drug plan if the caller has questions about the coverage gap and/or wants to know if they have reached the coverage gap.
SCRIPT = Out of Pocket TROOP
SCRIPT = Late Enrollment Penalty
SCRIPT = CS Medicare.gov Tools
REFERENCE MATERIALS = Definitions document, for explanation of these terms

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2008 COST

TOP BACK

****Use this section ONLY if caller does not have LIS.****

2008 Medicare minimum standard coverage (this is an example, but stress that plan coverage varies):
The expected average premium for a Medicare drug plan in 2008 will be about $25.00. Premiums for some plans may be higher or lower, and you may be able to get a plan without a monthly premium, deductible, or coverage gap.

For a minimum standard plan in 2008, you will pay the first $275 for your drugs. This amount is your DEDUCTIBLE.

After you pay the yearly deductible, here's how the costs will work in 2008:

- You pay 25% of your yearly drug costs, from $275 to $2,510, and your plan pays the other 75% of these costs. This means you pay $558.75 out-of-pocket during this phase of the benefit. This period is the INITIAL COVERAGE LEVEL. The costs until the end of the initial coverage level are based on the full cost of the drugs.
- You pay 100% of the next $3,216.25 in drug costs until you reach $4,050 in out-of-pocket costs. This amount is the COVERAGE GAP. (****CSR NOTE**: $275 deductible + $558.75 (25% share of $275 to $2510) + $3,216.25 = $4,050 out-of-pocket cost.**)
- After you have spent $4,050 out-of-pocket, you pay 5% of your drug costs (or a small copayment) for the rest of the calendar year and your plan pays the rest. This is CATASTROPHIC COVERAGE.

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LATE ENROLLMENT PENALTY

TOP BACK

If you don't join a Medicare prescription drug plan when you're first eligible, you'll have to wait until your next enrollment opportunity to join a drug plan, and you may have to pay a higher premium because of a late enrollment penalty. If your Medicare drug plan determines that you have a continuous period of 63 days or more without creditable drug coverage (coverage that is at least as good as Medicare's coverage), you will receive a late enrollment penalty letter, a reconsideration notice and a reconsideration request form. If you are assessed a late enrollment penalty, the amount will be billed or deducted with your drug plan premium.

If you **drop** your Medicare drug coverage and you have a break in drug coverage of 63 days or more, your premium may be increased by a penalty for being without creditable prescription drug coverage.

You won't have to pay a late enrollment penalty if you currently have creditable drug coverage. To find out if your drug coverage is as good as Medicare's drug coverage, you need to ask the organization that offers your prescription drug coverage. They may have already sent you a written notice explaining whether the coverage is creditable.

If your creditable coverage ends, you'll get a special enrollment period (SEP) that begins the month that you're told of the loss of coverage and either ends 60 days after the loss or 60 days after you're told, whichever is later. If you don't join a plan during this SEP, you'll have to wait until the next enrollment period and you will have to pay a penalty. In most cases, the next valid enrollment opportunity will be November 15th - December 31st. If you enroll during this time, your coverage will start on January 1st of the next year. (SCRIPT: Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage.)

If you are **under the age of 65 and disabled** and you decide to pick up Medicare's drug coverage at a later date, but before you turn 65, you will have to pay a penalty. Once you turn age 65, you will get a new initial enrollment period to add drug coverage and the penalty will be dropped.

If the caller asks what his or her premium penalty is, or if you need an example, **CLICK HERE**.

If the caller qualifies for the extra help, **CLICK HERE** for more information.

If you file for reconsideration to have your late enrollment penalty reduced or dropped, the plan will still bill you for the penalty until a decision has been made. If you are in direct-bill status and you do not pay the late enrollment penalty, you can be disenrolled from the drug plan for non-payment of premiums. (****CSR NOTE**: For more information about the reconsideration process, go to script RP Drug Coverage Denial Claim Enrollment Appeal.****)

TOP BACK

TIP BOX:

SCRIPT = RP Drug Coverage Denial Claim Enrollment Appeal
TIP = If you lived in an area that was affected by Hurricane Katrina, and you enrolled in a Medicare drug plan by December 31, 2006, you won't have to pay a penalty.
TIP = If you were affected by Hurricane Rita or Wilma and did not enroll when you were first eligible, you may have to pay a higher premium because of a late enrollment penalty.

TOP BACK

LATE ENROLLMENT PENALTY (EXAMPLE)

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I can't tell you what the exact amount of your penalty would be, if one applies to you. I can only tell you how to get a very rough estimate. To estimate the penalty, find the national base beneficiary premium for the year ($27.35 in 2007, $27.93 in 2008) and take 1% of that ($.27 in 2007, $.279 in 2008). Multiply it by the number of uncovered, full calendar months (during any continuous period of 63 days or more), since the end of your initial enrollment period, during which you did not have creditable coverage. Take the answer and round it to the nearest ten cents. This is the estimated monthly penalty amount that will be added to your plan's premium as long as you have Medicare drug coverage. This amount will be added even if the plan's premium is $0. Your penalty will change each year that the national average premium changes.

(**The 63-day continuous period** begins on the day after the beneficiary's initial enrollment period has ended and ends the day before his or her enrollment into a Medicare drug plan becomes effective.)

Example: Let's say you decided to enroll in Medicare's drug coverage starting January 1, 2007, but your initial enrollment period ended on May 15, 2006 and you didn't have other drug coverage that was as good as Medicare's. This means that you will be assessed a 7% penalty because you were without coverage for 7 full months (June - December). Your penalty will be 7% of the base beneficiary premium for 2007 or $1.90 per month. This amount will be added to your plan's premium.

You must enroll in a Medicare drug plan to know for sure if the penalty applies to you, and if so, how much it will be. I do not have personalized information on this. Unless you enroll, the Medicare drug plan will not be able to tell you the exact amount either. Once you enroll, the Medicare drug plan will inform the Centers for Medicare and Medicaid Services (CMS) of any gaps in coverage and the plan will be able to tell you the total premium amount, including any penalty, if one applies. If a penalty applies to you, it will be collected when you pay your plan premiums.

TOP BACK

TIP BOX:

SCRIPT = RP Drug Coverage Denial Claim Enrollment Appeal
REFERRAL = Medicare drug plan

TOP BACK

LATE ENROLLMENT PENALTY (EXTRA HELP)

TOP BACK

If you qualify for the extra help but did not join a Medicare drug plan when you were first eligible, you will not have to pay a late enrollment penalty as long as you join a Medicare drug plan by December 31, **2007** and you remain continuously enrolled.

In 2008, if you disenroll or haven't joined a plan and have a continuous period of 63 days or more without drug coverage, a late enrollment penalty will be applied when you re-enroll into a Medicare drug plan. However, the months in which you did not have drug coverage in **2006 and 2007** will **not** be included when the penalty is calculated.

OUT OF POCKET TROOP

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Certain payments made while in a Medicare drug plan are known as true out-of-pocket costs (TROOP). These costs are extremely important in determining whether you have entered the catastrophic coverage phase of the benefit. For every month that you buy covered drugs, you will receive an Explanation of Benefits that shows your total out-of-pocket costs to date. If you switch to another plan during the calendar year (January - December), your out-of-pocket costs will transfer with you.

Payments that count toward TROOP costs are:

1. Annual deductible
2. Amount paid for each drug
3. Payments made during the coverage gap. Costs during this time will only count if the drugs:
   • Are on the plan formulary
   • Weren't on the formulary, but were allowed to count toward your out-of-pocket costs by a coverage determination, exceptions process, or special appeal
   • Were purchased at an out-of-network pharmacy with plan permission

You may use a discount card or other pharmacy discount during the gap. Submit receipts to the plan so these purchases count toward TROOP costs.

These costs WILL NEVER count toward TROOP costs:

- Your premium
- Drugs purchased outside the United States and its territories
- Drugs not covered by your plan
- Drugs covered by your plan that are excluded by Medicare law
- Over-the-counter drugs or vitamins (even if required by your plan as part of step therapy)

Payments WILL count as TROOP costs if they are made by:

- Family members
- **Qualified** State Pharmacy Assistance Programs (SPAPs)
  (****CSR NOTE**: Refer to Reference Material document State Pharmacy Assistance Programs (SPAP) and Part D for a list of Qualified SPAPs.**)
- Medicare's extra help
- Most charities (unless established, run or controlled by a current or former employer/ union)

Payments WILL NOT count as TROOP costs if they are made by:

- Group Health Plans
- Your Medicare drug plan
- Insurance Plans (includes Medigap and supplemental insurance)
- Other third party groups (ex: TRICARE, Workers Comp)
- Government programs
- Non-Qualified State Pharmacy Assistance Programs (SPAPs)
- Pharmaceutical Manufacturer Patient Assistance Programs (PAPs)
- Medicaid
- Aids Drug Assistance Programs (ADAPs)
- Health Reimbursement Accounts (for non-working, aged beneficiaries)

If you have coverage from a third party that pays part of your TROOP costs, notify your Medicare drug plan.

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TIP BOX:

SCRIPT = Drug Coverage and Other Coverage
SCRIPT = Coverage Gap Donut Hole
REFERENCE MATERIAL = State Pharmacy Assistance Programs (SPAP) and Part D (for names of Qualified SPAPs and includes information on SPAP wraparound programs)

TOP BACK

HOW TO PAY YOUR PREMIUMS

TOP BACK

Premium Payment Methods:
When you join a plan, you will be asked how you would like to pay for your premiums. The three options available are:

1. Give your plan permission to deduct the premium from a savings or checking account, or charge to a credit / debit card.
2. Have your plan bill you and then send a check or money order to your plan.
3. Have your premium taken out of your Social Security benefits every month. (This is similar to the way that some Part B premiums are paid.) The premium cannot be taken out of Civil Service or Railroad Retirement Board benefits at this time.

****CSR NOTE**: If someone chooses option #1 or #2 above, they may be billed for their premiums on a monthly, quarterly, or other basis. It is up to the plan to decide how often they will bill for their premiums, but the plan must at least offer monthly billing.**

Once the plan processes your enrollment, premium payment information is submitted

electronically to the Centers for Medicare and Medicaid Services (CMS). Then, CMS either:

- notifies the plan to bill you directly for the premium OR
- electronically notifies the Social Security Administration (SSA) to automatically withhold the premium from your monthly SSA benefits.

Once automatic withholding has started, the plan premium will be deducted from your Social Security benefits for the same month of coverage. For example, your June Social Security benefit will have a deduction for June's premium.

If you want to change your method of payment, you will need to contact your plan.

ADDITIONAL INFORMATION:
If you disenroll or switch plans, your enrollment in a new plan will automatically stop the premium deduction from your old plan. You cannot be charged for 2 plans' premiums for the same month.

If you have a secondary insurance that pays a portion of your drug plan premium and you choose to have automatic premium withholding from your SSA benefits, the entire premium amount will be deducted. Your drug plan will then send you a refund for the overpayment of premiums. If you do not wish to have the entire premium deducted from your SSA benefits, you can choose to pay the premiums directly to the plan (this will mean you would only pay your portion of the premium and your secondary insurer would pay their portion).

****CSR NOTE:** Verify that the caller is not affected by the SSA premium issues before reading this information.**
It can take as long as 3 months for changes in your premium payment method to be reflected in all of the systems. If you want to verify your premium payment method, please contact your plan.

> **For example,** if you request a change in your premium payment method in mid-November, the change will be effective in December. However, the change may not show in Social Security's records until January or February.

TOP BACK

TIP BOX:

REFERRAL = The Plan. Do not refer callers to SSA for questions about Medicare drug plan premiums.
SCRIPT = Delay in Premium Payment, if caller switched plans and premiums are still being deducted from SSA benefits for old plan.

DELAY IN PREMIUM PAYMENT

TOP BACK

If caller says their premiums are not being deducted from their SSA benefits, ASK:
How long has it been since you requested to have your premiums deducted?

> **3+ MONTHS:** **Have the caller pass Disclosure and GO TO the Surveys tab. Follow the script "Premium Refund Issue Lookup."**
>
> **LESS THAN 3 MONTHS:** It can take several months for premiums to start being deducted from SSA benefits. Do not send a payment check to your plan during this time. When the withdrawal begins, you'll see a deduction for the months during which you had coverage, but the premium wasn't withheld from your check. This is a one-time occurrence and future deductions will be for one month of premiums.

Deduction request was initially accepted but now premiums are not being deducted: If there is a discrepancy in the amount that should be withheld from your SSA benefits, the deduction will stop. If this happens, Medicare will ask your drug plan to bill you directly for your premiums. Call your plan if you want to know why your deductions stopped.

Request for premium deduction was rejected: If the request to have your premiums taken from your SSA benefits is rejected, your plan will contact you about payment options. This might happen if your monthly Social Security benefits are not enough to cover your drug plan premiums.

Plan says premiums are not being paid: **Have the caller pass Disclosure and GO TO the Surveys tab. Follow the script "Premium Refund Issue Lookup."**

Caller previously had automatic deduction and requested a change to direct billing: If you previously had automatic deduction and requested a change to direct billing, your premiums may continue to be deducted. If this happens, you will receive a separate refund. Premiums will be refunded back to the date your direct billing began.

ADDITIONAL INFORMATION:
If you disenroll or switch plans, premiums from the old plan may still be deducted from your SSA benefits. As soon as the systems are updated, SSA will refund any premiums paid to the first plan. You should get this refund within 3 months after enrolling in a new plan. You do not need to do anything.
****CSR NOTE:** If the caller has already talked to the plan and has not gotten a refund within 3 months, check the "Premium Refund Issue Lookup" in the Surveys tab.**

TOP BACK

TIP BOX:

SCRIPT = Premium Refund Issue Lookup (in the Surveys tab)
REFERRAL = Do **not** refer callers to SSA for questions about Medicare drug plan premiums. These questions should be referred to the drug plan.

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COVERAGE GAP DONUT HOLE

TOP BACK

The coverage gap, sometimes called the "donut hole," is the period in which you pay 100% of your drug costs. Keep in mind that your costs start over at the beginning of each calendar year (January - December).

****CSR NOTE:** If caller wants to know about the coverage gap in 2008, **click here**.

Based on Medicare's minimum standard coverage, the coverage gap will work this way (use this as an EXAMPLE ONLY because plans vary):
When the total cost (what you and your plan pay) for your drugs reaches $2,400, you will enter the coverage gap. You will then have to pay 100% of your drug costs (negotiated price, not the full retail price) until you have spent $3,850 in out-of-pocket costs for the year. This would mean that you will spend $3051.25 in drug costs while in the coverage gap.

CSR NOTE: $265 (deductible) + $533.75 (25% of $265 to $2400) + $3,051.25 (cost while in coverage gap) = $3850 out-of-pocket costs.

If you qualify for the extra help, you will not have a coverage gap. Instead, you will pay a small copayment or coinsurance amount. What you pay at this time **may** be greater than the amount you paid previously for your drugs. However, this amount will never be more than the copay/coinsurance amount for which you were approved. ****CSR NOTE:** If caller wants to know their copay amount, GO TO the MA PDP tab.**

Some plans offer coverage while you're in the coverage gap. There is at least one plan in each state that offers some coverage during the coverage gap. Unless you switch to one of these plans during a valid enrollment period, you can't avoid the gap by switching drug plans during the year. A record of your drug costs will transfer with you to your new drug plan. If you want to know if you have reached the coverage gap, please contact your plan.

If your plan has a coverage gap, you may be able to avoid, or delay reaching, the coverage gap and continue saving on drug costs.

Would you like more information on this? **Click Here** to give caller additional information from "5 Ways to Lower Your Costs During the Coverage Gap" on www.medicare.gov.

****CSR NOTE**: Use the CSR Plan Finder Tool to help caller estimate when they will enter the

Coverage Gap. On the Prescription Drug Plan Comparison page, choose "View Cost Details" from the "More About This Plan" section. The Total Monthly Cost Estimator is a bar chart that shows when the person will enter the gap.**

TOP BACK

TIP BOX:

SCRIPT = Cost
SCRIPT = LIS Cost
SCRIPT = Out of Pocket TROOP, if caller wants information on what counts toward their out-of-pocket costs.
SCRIPT = CS Medicare.gov Tools
SCRIPT = Drug Coverage LIS Extra Help Apply
SCRIPT = Drug Coverage and Other Coverage
REFERENCE MATERIAL = State Pharmacy Assistance Programs (SPAP) and Part D (includes information on SPAP wraparound programs)
FULFILLMENT = Bridging the Coverage Gap (11213)

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2008 COVERAGE GAP DONUT HOLE

TOP BACK

Based on Medicare's minimum standard coverage, the coverage gap will work this way in 2008 (stress to the caller that plans vary):
When the total cost (what you and your plan pay) for your drugs reaches $2,510, you enter the coverage gap. You then have to pay 100% of your drug costs (negotiated price, not the full retail price) until you reach $4,050 in out-of-pocket costs for the year. This means that you have spent $3,216.25 in drug costs while in the coverage gap.

****CSR NOTE**: $275 deductible + $558.75 (25% of $275 to $2510) + $3,216.25 = $4,050 out-of-pocket cost.****

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DRUG COVERAGE LIS COST

TOP BACK

****CSR NOTE: If caller wants to know the amount that they were approved for, use the Limited Income Subsidy History applet or Deemed History applet in the MA PDP Tab. If caller wants to know exactly how much they will have to pay in a particular plan, use the CSR Plan Finder Tool and authenticate.****

Deemed Copay Level	2007 Copay Level	2008 Copay Level
1	HIGH ($2.15/$5.35)	HIGH ($2.25/$5.60)
2	LOW ($1.00/$3.10)	LOW ($1.05/$3.10)
3	No Copay	No Copay
4	15% Coinsurance	15% Coinsurance

If caller is deemed eligible for the extra help or applied and was awarded the full (100%) subsidy (Part D Subsidy Level, in LIS History), READ:
Since you qualify for extra help, you will either pay no deductible or a $53 deductible ($56 in 2008) and a small amount for each covered prescription you have filled. There may be plans available in which you would pay no monthly premium. There are other plans where you would have to pay a portion of the premium. Be sure to ask about the premium when you are comparing plans.

If caller applied and was awarded a partial (25, 50, or 75%) subsidy (Part D Subsidy Level, in LIS History), READ:
Since you were approved for this extra help, you will pay a lower monthly premium. Your premium will be reduced based on the percentage listed in your award letter. You will also have a reduced deductible and copayments when you get a covered prescription filled. These amounts will vary depending upon which Medicare drug plan you are enrolled in. When you compare plans, ask how much your deductible and copayments would be for each plan.

If you qualify for the extra help retroactively, you can get reimbursed for any premiums and cost-sharing that you paid retroactive to the date that your extra help started. You will need to contact the plan to find out how to be reimbursed.

ADDITIONAL INFORMATION:
If you join a Medicare Advantage or other Medicare Health Plan that offers prescription drug coverage (MA-PD), your extra help will only be applied to the Medicare prescription drug coverage costs.

If you did not join a Medicare drug plan when you were first eligible AND you qualify for the extra help, you will not have to pay a late enrollment penalty as long as you join a Medicare drug plan by December 31, 2007. **In 2008**, if you disenroll or haven't joined a plan and have a continuous period of 63 days or more without drug coverage, a late enrollment penalty will be applied when you re-enroll into a Medicare drug plan. However, the months in which you did not have drug coverage in 2006 and 2007 will **not** be included when the penalty is calculated.

If you qualify for the extra help, you will not have a coverage gap. Instead, you will pay a small copayment or coinsurance amount. What you pay at this time **may** be greater than the amount you paid previously for your drugs. However, this amount will never be more than the copay/coinsurance amount for which you were approved. If you take a drug that is not on the plan's formulary, you will have to pay the full price for that drug, even if you are getting the extra help. ****CSR NOTE:** If caller wants their copay amount, GO TO the MA PDP tab.**

If your plan's monthly premium is more than $2 above the 2007 benchmark premium ($1 above in 2008) in your area, the extra help you receive will not cover the full cost of your plan's premium. This means that you will have to pay part of your premium. For example, if the benchmark premium in your area is $26.50 and your plan's premium is $29.50, you are responsible for paying the additional $3.00 per month to your plan.
****CSR NOTE:** GO TO the Reference Materials document "2007 Low Income Subsidy Premium Amounts" to find the 2007 LIS benchmark premium for caller's area.**

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TIP BOX:

REFERRAL = Medicare prescription drug plan, if caller feels that they are being charged the wrong copayment amount or they have any other cost-related questions about their plan.
SCRIPT = Coverage Gap Donut Hole
SCRIPT = Drug Coverage LIS Auto Facilitated Enrollment How to Enroll
SCRIPT = Drug Coverage LIS Extra Help Apply, for information about the award letters.
REFERENCE MATERIAL = 2007 Low Income Subsidy Premium Amounts

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Drug Coverage Cost Information

START » **Use this script for information about drug coverage costs.**

» Click on one of the links below for information on drug coverage costs:

COST	**LIS COST**	**COVERAGE GAP DONUT HOLE**
LATE ENROLLMENT PENALTY	**OUT OF POCKET TROOP**	**HOW TO PAY YOUR PREMIUMS**
	DELAY IN PREMIUM PAYMENT	

2007 COST

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****Use this section ONLY if caller does not have LIS.****

Medicare drug plans vary. This means that monthly premiums, deductibles, copayments, and formularies differ depending on the plan. Your costs also depend on which drugs you use and if you get extra help. **Costs vary from year to year and start over each calendar year (January - December).** This means that you will have to meet the deductible each year and your premiums, deductibles, and copays may change.

Plans must offer coverage that is as good as the Medicare minimum standard coverage.

****CSR NOTE:** If caller wants to know about the costs in 2008, **click here**.

2007 Medicare minimum standard coverage (this is an example, but stress that all plans vary):
When you join, you'll pay a monthly premium in addition to other Medicare premiums you pay now. The 2007 average premium is about $27.35, but premiums may be higher or lower. You may be able to get a plan without a monthly premium, deductible or coverage gap.

For a minimum standard plan, you pay the first $265 for your drugs. This is called your DEDUCTIBLE. This amount may vary for other types of plans.

After you pay the yearly deductible, here's how the costs work in 2007:

- You pay 25% of your yearly drug costs, from $265 to $2,400, and your plan pays the other 75% of these costs. This means you pay $533.75 out-of-pocket for this phase of the benefit. This period is called the INITIAL COVERAGE LEVEL. Keep in mind that the costs until the end of the initial coverage level ($2,400) are based on the full cost of the drugs, not what you pay.

- You pay 100% of the next $3051.25 in drug costs until you have $3,850 in out-of-pocket costs. This amount is called the COVERAGE GAP. (CSR NOTE: $265 deductible + $533.75 (25% share of $265 to $2400) + $3051.25 = $3850 out-of-pocket cost.)
- After you have spent $3,850 out-of-pocket, you pay 5% of your drug costs (or a small copayment) for the rest of the calendar year and your plan pays the rest. This is called CATASTROPHIC COVERAGE.

Some plans may have a different structure, including a set copayment amount (specific dollar amount) instead of a coinsurance (a percentage of the drug cost), different limits on the initial coverage level and coverage gap. Payments made for monthly premiums or toward drugs not covered by the plan (due to not being on the formulary or being excluded by Medicare Law) will not count toward your deductible, initial coverage level, or catastrophic coverage.

****CSR NOTE:** Use the CSR Plan Finder Tool for cost information on each plan.**

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TIP BOX:

SCRIPT = Coverage Gap Donut Hole
REFERRAL = Medicare prescription drug plan, if caller feels that they are being charged the wrong copayment amount or they have any other cost-related questions about their plan. You can also refer to the drug plan if the caller has questions about the coverage gap and/or wants to know if they have reached the coverage gap.
SCRIPT = Out of Pocket TROOP
SCRIPT = Late Enrollment Penalty
SCRIPT = CS Medicare.gov Tools
REFERENCE MATERIALS = Definitions document, for explanation of these terms

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2008 COST

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****Use this section ONLY if caller does not have LIS.****

2008 Medicare minimum standard coverage (this is an example, but stress that plan coverage varies):
The expected average premium for a Medicare drug plan in 2008 will be about $25.00. Premiums for some plans may be higher or lower, and you may be able to get a plan without a monthly premium, deductible, or coverage gap.

For a minimum standard plan in 2008, you will pay the first $275 for your drugs. This amount is your DEDUCTIBLE.

After you pay the yearly deductible, here's how the costs will work in 2008:

- You pay 25% of your yearly drug costs, from $275 to $2,510, and your plan pays the other 75% of these costs. This means you pay $558.75 out-of-pocket during this phase of the benefit. This period is the INITIAL COVERAGE LEVEL. The costs until the end of the initial coverage level are based on the full cost of the drugs.
- You pay 100% of the next $3,216.25 in drug costs until you reach $4,050 in out-of-pocket costs. This amount is the COVERAGE GAP. (****CSR NOTE**: $275 deductible + $558.75 (25% share of $275 to $2510) + $3,216.25 = $4,050 out-of-pocket cost.**)
- After you have spent $4,050 out-of-pocket, you pay 5% of your drug costs (or a small copayment) for the rest of the calendar year and your plan pays the rest. This is CATASTROPHIC COVERAGE.

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LATE ENROLLMENT PENALTY

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If you don't join a Medicare prescription drug plan when you're first eligible, you'll have to wait until your next enrollment opportunity to join a drug plan, and you may have to pay a higher premium because of a late enrollment penalty. If your Medicare drug plan determines that you have a continuous period of 63 days or more without creditable drug coverage (coverage that is at least as good as Medicare's coverage), you will receive a late enrollment penalty letter, a reconsideration notice and a reconsideration request form. If you are assessed a late enrollment penalty, the amount will be billed or deducted with your drug plan premium.

If you **drop** your Medicare drug coverage and you have a break in drug coverage of 63 days or more, your premium may be increased by a penalty for being without creditable prescription drug coverage.

You won't have to pay a late enrollment penalty if you currently have creditable drug coverage. To find out if your drug coverage is as good as Medicare's drug coverage, you need to ask the organization that offers your prescription drug coverage. They may have already sent you a written notice explaining whether the coverage is creditable.

If your creditable coverage ends, you'll get a special enrollment period (SEP) that begins the month that you're told of the loss of coverage and either ends 60 days after the loss or 60 days after you're told, whichever is later. If you don't join a plan during this SEP, you'll have to wait until the next enrollment period and you will have to pay a penalty. In most cases, the next valid enrollment opportunity will be November 15th - December 31st. If you enroll during this time, your coverage will start on January 1st of the next year. (SCRIPT: Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage.)

If you are **under the age of 65 and disabled** and you decide to pick up Medicare's drug coverage at a later date, but before you turn 65, you will have to pay a penalty. Once you turn age 65, you will get a new initial enrollment period to add drug coverage and the penalty will be dropped.

If the caller asks what his or her premium penalty is, or if you need an example, **CLICK HERE**.

If the caller qualifies for the extra help, **CLICK HERE** for more information.

If you file for reconsideration to have your late enrollment penalty reduced or dropped, the plan will still bill you for the penalty until a decision has been made. If you are in direct-bill status and you do not pay the late enrollment penalty, you can be disenrolled from the drug plan for non-payment of premiums. (****CSR NOTE**: For more information about the reconsideration process, go to script RP Drug Coverage Denial Claim Enrollment Appeal.****)

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TIP BOX:

SCRIPT = RP Drug Coverage Denial Claim Enrollment Appeal
TIP = If you lived in an area that was affected by Hurricane Katrina, and you enrolled in a Medicare drug plan by December 31, 2006, you won't have to pay a penalty.
TIP = If you were affected by Hurricane Rita or Wilma and did not enroll when you were first eligible, you may have to pay a higher premium because of a late enrollment penalty.

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LATE ENROLLMENT PENALTY (EXAMPLE)

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I can't tell you what the exact amount of your penalty would be, if one applies to you. I can only tell you how to get a very rough estimate. To estimate the penalty, find the national base beneficiary premium for the year ($27.35 in 2007, $27.93 in 2008) and take 1% of that ($.27 in 2007, $.279 in 2008). Multiply it by the number of uncovered, full calendar months (during any continuous period of 63 days or more), since the end of your initial enrollment period, during which you did not have creditable coverage. Take the answer and round it to the nearest ten cents. This is the estimated monthly penalty amount that will be added to your plan's premium as long as you have Medicare drug coverage. This amount will be added even if the plan's premium is $0. Your penalty will change each year that the national average premium changes.

(**The 63-day continuous period** begins on the day after the beneficiary's initial enrollment period has ended and ends the day before his or her enrollment into a Medicare drug plan becomes effective.)

Example: Let's say you decided to enroll in Medicare's drug coverage starting January 1, 2007, but your initial enrollment period ended on May 15, 2006 and you didn't have other drug coverage that was as good as Medicare's. This means that you will be assessed a 7% penalty because you were without coverage for 7 full months (June - December). Your penalty will be 7% of the base beneficiary premium for 2007 or $1.90 per month. This amount will be added to your plan's premium.

You must enroll in a Medicare drug plan to know for sure if the penalty applies to you, and if so, how much it will be. I do not have personalized information on this. Unless you enroll, the Medicare drug plan will not be able to tell you the exact amount either. Once you enroll, the Medicare drug plan will inform the Centers for Medicare and Medicaid Services (CMS) of any gaps in coverage and the plan will be able to tell you the total premium amount, including any penalty, if one applies. If a penalty applies to you, it will be collected when you pay your plan premiums.

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TIP BOX:

SCRIPT = RP Drug Coverage Denial Claim Enrollment Appeal
REFERRAL = Medicare drug plan

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LATE ENROLLMENT PENALTY (EXTRA HELP)

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If you qualify for the extra help but did not join a Medicare drug plan when you were first eligible, you will not have to pay a late enrollment penalty as long as you join a Medicare drug plan by December 31, **2007** and you remain continuously enrolled.

In 2008, if you disenroll or haven't joined a plan and have a continuous period of 63 days or more without drug coverage, a late enrollment penalty will be applied when you re-enroll into a Medicare drug plan. However, the months in which you did not have drug coverage in **2006 and 2007** will **not** be included when the penalty is calculated.

OUT OF POCKET TROOP

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Certain payments made while in a Medicare drug plan are known as true out-of-pocket costs (TROOP). These costs are extremely important in determining whether you have entered the catastrophic coverage phase of the benefit. For every month that you buy covered drugs, you will receive an Explanation of Benefits that shows your total out-of-pocket costs to date. If you switch to another plan during the calendar year (January - December), your out-of-pocket costs will transfer with you.

Payments that count toward TROOP costs are:

1. Annual deductible
2. Amount paid for each drug
3. Payments made during the coverage gap. Costs during this time will only count if the drugs:
   • Are on the plan formulary
   • Weren't on the formulary, but were allowed to count toward your out-of-pocket costs by a coverage determination, exceptions process, or special appeal
   • Were purchased at an out-of-network pharmacy with plan permission

You may use a discount card or other pharmacy discount during the gap. Submit receipts to the plan so these purchases count toward TROOP costs.

These costs WILL NEVER count toward TROOP costs:

- Your premium
- Drugs purchased outside the United States and its territories
- Drugs not covered by your plan
- Drugs covered by your plan that are excluded by Medicare law
- Over-the-counter drugs or vitamins (even if required by your plan as part of step therapy)

Payments WILL count as TROOP costs if they are made by:

- Family members
- **Qualified** State Pharmacy Assistance Programs (SPAPs)
  (****CSR NOTE**: Refer to Reference Material document State Pharmacy Assistance Programs (SPAP) and Part D for a list of Qualified SPAPs.**)
- Medicare's extra help
- Most charities (unless established, run or controlled by a current or former employer/ union)

Payments WILL NOT count as TROOP costs if they are made by:

- Group Health Plans
- Your Medicare drug plan
- Insurance Plans (includes Medigap and supplemental insurance)
- Other third party groups (ex: TRICARE, Workers Comp)
- Government programs
- Non-Qualified State Pharmacy Assistance Programs (SPAPs)
- Pharmaceutical Manufacturer Patient Assistance Programs (PAPs)
- Medicaid
- Aids Drug Assistance Programs (ADAPs)
- Health Reimbursement Accounts (for non-working, aged beneficiaries)

If you have coverage from a third party that pays part of your TROOP costs, notify your Medicare drug plan.

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TIP BOX:

SCRIPT = Drug Coverage and Other Coverage
SCRIPT = Coverage Gap Donut Hole
REFERENCE MATERIAL = State Pharmacy Assistance Programs (SPAP) and Part D (for names of Qualified SPAPs and includes information on SPAP wraparound programs)

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HOW TO PAY YOUR PREMIUMS

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Premium Payment Methods:
When you join a plan, you will be asked how you would like to pay for your premiums. The three options available are:

1. Give your plan permission to deduct the premium from a savings or checking account, or charge to a credit / debit card.
2. Have your plan bill you and then send a check or money order to your plan.
3. Have your premium taken out of your Social Security benefits every month. (This is similar to the way that some Part B premiums are paid.) The premium cannot be taken out of Civil Service or Railroad Retirement Board benefits at this time.

****CSR NOTE**: If someone chooses option #1 or #2 above, they may be billed for their premiums on a monthly, quarterly, or other basis. It is up to the plan to decide how often they will bill for their premiums, but the plan must at least offer monthly billing.**

Once the plan processes your enrollment, premium payment information is submitted

electronically to the Centers for Medicare and Medicaid Services (CMS). Then, CMS either:

- notifies the plan to bill you directly for the premium OR
- electronically notifies the Social Security Administration (SSA) to automatically withhold the premium from your monthly SSA benefits.

Once automatic withholding has started, the plan premium will be deducted from your Social Security benefits for the same month of coverage. For example, your June Social Security benefit will have a deduction for June's premium.

If you want to change your method of payment, you will need to contact your plan.

ADDITIONAL INFORMATION:
If you disenroll or switch plans, your enrollment in a new plan will automatically stop the premium deduction from your old plan. You cannot be charged for 2 plans' premiums for the same month.

If you have a secondary insurance that pays a portion of your drug plan premium and you choose to have automatic premium withholding from your SSA benefits, the entire premium amount will be deducted. Your drug plan will then send you a refund for the overpayment of premiums. If you do not wish to have the entire premium deducted from your SSA benefits, you can choose to pay the premiums directly to the plan (this will mean you would only pay your portion of the premium and your secondary insurer would pay their portion).

****CSR NOTE:** Verify that the caller is not affected by the SSA premium issues before reading this information.**
It can take as long as 3 months for changes in your premium payment method to be reflected in all of the systems. If you want to verify your premium payment method, please contact your plan.

> **For example,** if you request a change in your premium payment method in mid-November, the change will be effective in December. However, the change may not show in Social Security's records until January or February.

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TIP BOX:

REFERRAL = The Plan. Do not refer callers to SSA for questions about Medicare drug plan premiums.
SCRIPT = Delay in Premium Payment, if caller switched plans and premiums are still being deducted from SSA benefits for old plan.

DELAY IN PREMIUM PAYMENT

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If caller says their premiums are not being deducted from their SSA benefits, ASK:
How long has it been since you requested to have your premiums deducted?

> **3+ MONTHS:** **Have the caller pass Disclosure and GO TO the Surveys tab. Follow the script "Premium Refund Issue Lookup."**
>
> **LESS THAN 3 MONTHS:** It can take several months for premiums to start being deducted from SSA benefits. Do not send a payment check to your plan during this time. When the withdrawal begins, you'll see a deduction for the months during which you had coverage, but the premium wasn't withheld from your check. This is a one-time occurrence and future deductions will be for one month of premiums.

Deduction request was initially accepted but now premiums are not being deducted: If there is a discrepancy in the amount that should be withheld from your SSA benefits, the deduction will stop. If this happens, Medicare will ask your drug plan to bill you directly for your premiums. Call your plan if you want to know why your deductions stopped.

Request for premium deduction was rejected: If the request to have your premiums taken from your SSA benefits is rejected, your plan will contact you about payment options. This might happen if your monthly Social Security benefits are not enough to cover your drug plan premiums.

Plan says premiums are not being paid: **Have the caller pass Disclosure and GO TO the Surveys tab. Follow the script "Premium Refund Issue Lookup."**

Caller previously had automatic deduction and requested a change to direct billing: If you previously had automatic deduction and requested a change to direct billing, your premiums may continue to be deducted. If this happens, you will receive a separate refund. Premiums will be refunded back to the date your direct billing began.

ADDITIONAL INFORMATION:
If you disenroll or switch plans, premiums from the old plan may still be deducted from your SSA benefits. As soon as the systems are updated, SSA will refund any premiums paid to the first plan. You should get this refund within 3 months after enrolling in a new plan. You do not need to do anything.
****CSR NOTE:** If the caller has already talked to the plan and has not gotten a refund within 3 months, check the "Premium Refund Issue Lookup" in the Surveys tab.**

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TIP BOX:

SCRIPT = Premium Refund Issue Lookup (in the Surveys tab)
REFERRAL = Do **not** refer callers to SSA for questions about Medicare drug plan premiums. These questions should be referred to the drug plan.

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COVERAGE GAP DONUT HOLE

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The coverage gap, sometimes called the "donut hole," is the period in which you pay 100% of your drug costs. Keep in mind that your costs start over at the beginning of each calendar year (January - December).

****CSR NOTE:** If caller wants to know about the coverage gap in 2008, **click here**.

Based on Medicare's minimum standard coverage, the coverage gap will work this way (use this as an EXAMPLE ONLY because plans vary):
When the total cost (what you and your plan pay) for your drugs reaches $2,400, you will enter the coverage gap. You will then have to pay 100% of your drug costs (negotiated price, not the full retail price) until you have spent $3,850 in out-of-pocket costs for the year. This would mean that you will spend $3051.25 in drug costs while in the coverage gap.

CSR NOTE: $265 (deductible) + $533.75 (25% of $265 to $2400) + $3,051.25 (cost while in coverage gap) = $3850 out-of-pocket costs.

If you qualify for the extra help, you will not have a coverage gap. Instead, you will pay a small copayment or coinsurance amount. What you pay at this time **may** be greater than the amount you paid previously for your drugs. However, this amount will never be more than the copay/coinsurance amount for which you were approved. ****CSR NOTE:** If caller wants to know their copay amount, GO TO the MA PDP tab.**

Some plans offer coverage while you're in the coverage gap. There is at least one plan in each state that offers some coverage during the coverage gap. Unless you switch to one of these plans during a valid enrollment period, you can't avoid the gap by switching drug plans during the year. A record of your drug costs will transfer with you to your new drug plan. If you want to know if you have reached the coverage gap, please contact your plan.

If your plan has a coverage gap, you may be able to avoid, or delay reaching, the coverage gap and continue saving on drug costs.

Would you like more information on this? **Click Here** to give caller additional information from "5 Ways to Lower Your Costs During the Coverage Gap" on www.medicare.gov.

****CSR NOTE**: Use the CSR Plan Finder Tool to help caller estimate when they will enter the

Coverage Gap. On the Prescription Drug Plan Comparison page, choose "View Cost Details" from the "More About This Plan" section. The Total Monthly Cost Estimator is a bar chart that shows when the person will enter the gap.**

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TIP BOX:

SCRIPT = Cost
SCRIPT = LIS Cost
SCRIPT = Out of Pocket TROOP, if caller wants information on what counts toward their out-of-pocket costs.
SCRIPT = CS Medicare.gov Tools
SCRIPT = Drug Coverage LIS Extra Help Apply
SCRIPT = Drug Coverage and Other Coverage
REFERENCE MATERIAL = State Pharmacy Assistance Programs (SPAP) and Part D (includes information on SPAP wraparound programs)
FULFILLMENT = Bridging the Coverage Gap (11213)

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2008 COVERAGE GAP DONUT HOLE

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Based on Medicare's minimum standard coverage, the coverage gap will work this way in 2008 (stress to the caller that plans vary):
When the total cost (what you and your plan pay) for your drugs reaches $2,510, you enter the coverage gap. You then have to pay 100% of your drug costs (negotiated price, not the full retail price) until you reach $4,050 in out-of-pocket costs for the year. This means that you have spent $3,216.25 in drug costs while in the coverage gap.

****CSR NOTE**: $275 deductible + $558.75 (25% of $275 to $2510) + $3,216.25 = $4,050 out-of-pocket cost.****

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DRUG COVERAGE LIS COST

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****CSR NOTE: If caller wants to know the amount that they were approved for, use the Limited Income Subsidy History applet or Deemed History applet in the MA PDP Tab. If caller wants to know exactly how much they will have to pay in a particular plan, use the CSR Plan Finder Tool and authenticate.****

Deemed Copay Level	2007 Copay Level	2008 Copay Level
1	HIGH ($2.15/$5.35)	HIGH ($2.25/$5.60)
2	LOW ($1.00/$3.10)	LOW ($1.05/$3.10)
3	No Copay	No Copay
4	15% Coinsurance	15% Coinsurance

If caller is deemed eligible for the extra help or applied and was awarded the full (100%) subsidy (Part D Subsidy Level, in LIS History), READ:
Since you qualify for extra help, you will either pay no deductible or a $53 deductible ($56 in 2008) and a small amount for each covered prescription you have filled. There may be plans available in which you would pay no monthly premium. There are other plans where you would have to pay a portion of the premium. Be sure to ask about the premium when you are comparing plans.

If caller applied and was awarded a partial (25, 50, or 75%) subsidy (Part D Subsidy Level, in LIS History), READ:
Since you were approved for this extra help, you will pay a lower monthly premium. Your premium will be reduced based on the percentage listed in your award letter. You will also have a reduced deductible and copayments when you get a covered prescription filled. These amounts will vary depending upon which Medicare drug plan you are enrolled in. When you compare plans, ask how much your deductible and copayments would be for each plan.

If you qualify for the extra help retroactively, you can get reimbursed for any premiums and cost-sharing that you paid retroactive to the date that your extra help started. You will need to contact the plan to find out how to be reimbursed.

ADDITIONAL INFORMATION:
If you join a Medicare Advantage or other Medicare Health Plan that offers prescription drug coverage (MA-PD), your extra help will only be applied to the Medicare prescription drug coverage costs.

If you did not join a Medicare drug plan when you were first eligible AND you qualify for the extra help, you will not have to pay a late enrollment penalty as long as you join a Medicare drug plan by December 31, 2007. **In 2008**, if you disenroll or haven't joined a plan and have a continuous period of 63 days or more without drug coverage, a late enrollment penalty will be applied when you re-enroll into a Medicare drug plan. However, the months in which you did not have drug coverage in 2006 and 2007 will **not** be included when the penalty is calculated.

If you qualify for the extra help, you will not have a coverage gap. Instead, you will pay a small copayment or coinsurance amount. What you pay at this time **may** be greater than the amount you paid previously for your drugs. However, this amount will never be more than the copay/coinsurance amount for which you were approved. If you take a drug that is not on the plan's formulary, you will have to pay the full price for that drug, even if you are getting the extra help. ****CSR NOTE:** If caller wants their copay amount, GO TO the MA PDP tab.**

If your plan's monthly premium is more than $2 above the 2007 benchmark premium ($1 above in 2008) in your area, the extra help you receive will not cover the full cost of your plan's premium. This means that you will have to pay part of your premium. For example, if the benchmark premium in your area is $26.50 and your plan's premium is $29.50, you are responsible for paying the additional $3.00 per month to your plan.
****CSR NOTE:** GO TO the Reference Materials document "2007 Low Income Subsidy Premium Amounts" to find the 2007 LIS benchmark premium for caller's area.**

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TIP BOX:

REFERRAL = Medicare prescription drug plan, if caller feels that they are being charged the wrong copayment amount or they have any other cost-related questions about their plan.
SCRIPT = Coverage Gap Donut Hole
SCRIPT = Drug Coverage LIS Auto Facilitated Enrollment How to Enroll
SCRIPT = Drug Coverage LIS Extra Help Apply, for information about the award letters.
REFERENCE MATERIAL = 2007 Low Income Subsidy Premium Amounts

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