BLUE CROSS AND BLUE SHIELD OF MINNESOTA

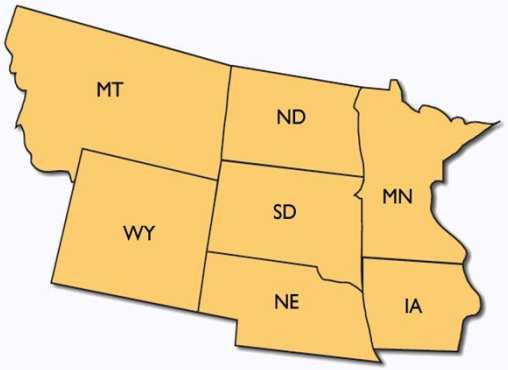
2014 MEDICAREBLUE RX℠ (PDP)

COURSE OBJECTIVES

- At the end of this course you should be able to:
  - Describe and differentiate between the two MedicareBlue Rx plan options
  - Explain the MedicareBlue Rx formulary and pharmacy network
  - Understand the importance of determining product suitability
  - Understand the importance of accurate completion and submission of enrollment forms
  - Describe to beneficiaries the sequence of events that will occur after they have submitted an enrollment form
  - Understand the limited instances in which disenrollment requests should be made

MEDICAREBLUE RX

- MedicareBlue Rx is a stand-alone Part D plan with two options (Standard and Premier) that is available to all eligible Medicare beneficiaries who:
  - Are entitled to Medicare Part A and/or enrolled in Medicare Part B
  - Permanently reside in the 7-state region
    - Wellmark Blue Cross and Blue Shield of Iowa*
    - Blue Cross and Blue Shield of Minnesota*
    - Blue Cross and Blue Shield of Montana*
    - Blue Cross and Blue Shield of Nebraska*
    - Blue Cross Blue Shield of North Dakota*
    - Wellmark Blue Cross and Blue Shield of South Dakota*
    - Blue Cross Blue Shield of Wyoming*



*An independent licensee of the Blue Cross and Blue Shield Association

MEDICAREBLUE RX

- 5-Star rated Part D plan in 2011, 2012 and 2013
  - One of only four Part D plans in the nation to achieve five stars in 2013
    - Medicare evaluates plans based on a 5-Star rating system; Star Ratings may change from one year to the next
    - Beneficiaries may be directed to **Medicare.gov** for more information
- Annual contract
  - MedicareBlue Rx is a plan with a Medicare contract that is renewed annually with CMS
  - Although coverage may renew each calendar year, MedicareBlue Rx options, benefits, features and premiums are subject to change annually

MEDICAREBLUE RX PREMIUM AND DEDUCTIBLE

	Standard		Premier	
	2014	2013	2014	2013
Monthly Premium	**$41.90**	$39.60	**$106.30**	$107
Yearly Deductible*	**$160**	$160	**$0**	$0

In addition to the monthly plan premium, members must also pay their Part B premiums (if enrolled), Part A premium if applicable, and any applicable income related premium adjustments

***Yearly Deductible = The amount a member is responsible for paying before the initial coverage begins

MEDICAREBLUE RX
INITIAL COVERAGE STAGE

	Standard		Premier	
	2014	2013	**2014**	2013
Tier 1: Preferred Generic drugs	**$4 copay**	$4 copay	**$3 copay**	$4 copay
Tier 2: Non-Preferred Generic drugs	**$18 copay**	$18 copay	**$8 copay**	$12 copay
Tier 3: Preferred Brand drugs	**$38 copay**	$40 copay	**$35 copay**	$40 copay
Tier 4: Non-Preferred Brand drugs	**48% coinsurance**	48% coinsurance	**45% coinsurance**	48% coinsurance

MedicareBlue Rx Standard – Includes a deductible, fixed copays on Tiers 1, 2 and 3 with coinsurance on Tier 4

MedicareBlue Rx Premier – No deductible, fixed copays on Tiers 1, 2 and 3 with coinsurance on Tier 4; fixed copays on Preferred Generic drugs and Non-Preferred Generic drugs during the coverage gap

MEDICAREBLUE RX COVERAGE GAP

This table shows the amount a member pays for a 31-day supply after total yearly covered prescription drug costs reach $2,850* in 2014 and $2,970* in 2013

MedicareBlue Rx Benefits	**2014 Standard Option**	2013 Standard Option	**2014 Premier Option**	2013 Premier Option
Coverage Gap	• **72% for Generic drugs** • **47.5% on some Brand drugs based on CMS agreement with drug manufacturers**	• 79% for Generic drugs • 47.5% on some Brand drugs based on CMS agreement with drug manufacturers	• **$3 copay for Tier 1 Preferred Generic drugs** • **$8 copay for Tier 2 Non-Preferred Generic drugs** • **72% for all other Generic drugs** • **47.5% on some Brand drugs based on CMS agreement with drug manufacturers**	• $4 copay for Tier 1 Preferred Generic drugs • $12 copay for Tier 2 Non-Preferred Generic drugs • 79% for all other Generic drugs • 47.5% on some Brand drugs based on CMS agreement with drug manufacturers

* Amount member has paid for covered drugs plus what the plan has paid for the calendar year. This does not include the premium the member pays.

MEDICAREBLUE RX CATASTROPHIC COVERAGE

This table shows the amount a member pays for a 31-day supply after $4,550* out -of-pocket prescription drug costs in 2014 and $4,750* out-of-pocket prescription drug costs in 2013

MedicareBlue Rx Benefits	**2014 Standard Option**	2013 Standard Option	**2014 Premier Option**	2013 Premier Option
Catastrophic Coverage	• **$2.55 copay for Generic drugs (including brand drugs treated as generic) and $6.35 copay for all other covered drugs OR 5% coinsurance, whichever is greater**	• $2.65 copay for Generic drugs (including brand drugs treated as generic) and $6.60 copay for all other covered drugs OR 5% coinsurance, whichever is greater	• **$2.55 copay for Generic drugs (including brand drugs treated as generic) and $6.35 copay for all other covered drugs OR 5% coinsurance, whichever is greater**	• $2.65 copay for Generic drugs (including brand drugs treated as generic) and $6.60 copay for all other covered drugs OR 5% coinsurance, whichever is greater

* Amount member has paid for covered drugs plus what the plan has paid for the calendar year. This does not include the premium the member pays.

MEDICAREBLUE RX FORMULARY MANAGEMENT

- Certain formulary prescriptions may be subject to limitations including step therapy, quantity limits, or prior authorization
  - For additional information, review the MedicareBlue Rx *Summary of Benefits*
- When working with clients to check coverage of their current drugs, it's important to explain the coverage of or restrictions to a drug they take
  - To get more information and/or check the formulary:
    - Go to **YourMedicareSolutions.com** and choose "Search drug list" then click on "Drug Formulary"
    - Go to **Medicare.gov**, follow the steps to enter the drugs you want to look at and then click on the plan name
    - Look in the plan's printed formulary booklet
    - Contact Customer Service

PART D PRESCRIPTION DRUG EXCLUSIONS

- Medicare Part D "Excluded Drugs" (as defined by statute):
  - Are not included in the formulary
  - Are not covered by MedicareBlue Rx
  - Are not eligible for exception requests
  - Are not included when calculating a member's "True Out-of-Pocket" (TrOOP) costs for catastrophic coverage benefits

- Prescriptions purchased outside the United States:
  - Are not covered by any Part D plan
  - Are not included when calculating a member's "True Out-of-Pocket" (TrOOP) costs for catastrophic coverage benefits

MEDICAREBLUE RX PHARMACY NETWORK

- Members must use participating pharmacies in our large, nationwide network to receive in-network benefits
  - Access to more than 64,000 pharmacies
    - Pre-negotiated reimbursement rates with pharmacy vendors that help keep costs down
    - Electronic claims processing by pharmacy

- Access the most current pharmacy directory: **YourMedicareSolutions.com**

USING OUT-OF-NETWORK PHARMACIES

- Out-of-network doesn't necessarily mean out-of-state since the MedicareBlue Rx pharmacy network is a national network
- When a network pharmacy is not accessible, an out-of-network pharmacy may be used (U.S. only), but the member will be responsible for:
  - Paying full retail cost of the prescription at the time of purchase
  - Submitting the claim for reimbursement
  - Paying all applicable deductibles, coinsurance, and co-payments, plus any charges over the negotiated reimbursement rate with in-network pharmacies
- Members utilizing out-of-network pharmacies in unusual circumstances are allowed to purchase only a 31-day supply of covered medications

MEDICAREBLUE RX ADDITIONAL COST-SAVINGS

- Members may wish to consider purchasing a 90-day supply to take advantage of additional cost-savings in the following ways:
  - From an in-network extended supply pharmacy (identified by EXT in the pharmacy directory) OR
  - Through one of the plan's two mail order pharmacies: PrimeMail* and Walgreens
- The cost through one of these methods for Standard and Premier members is two times the 31-day copay amount or the usual coinsurance
- These prescriptions are subject to formulary limitations

* PrimeMail is a mail-service pharmacy owned and operated by Prime Therapeutics, LLC

FEATURES OF MEDICAREBLUE RX

Medication Therapy Management (MTM)

- CMS requires plans to provide clinical management of prescriptions for populations with multiple chronic disease states at no additional cost to the member
- Program components are designed to optimize therapeutic outcomes for targeted beneficiaries
- Members must meet the CMS eligibility for MTM
- Members who are eligible for this free program will be automatically enrolled, unless they opt-out
- Prime Therapeutics* has a team of specialists, nurses and pharmacists dedicated to MTM

For more information go to **YourMedicareSolutions.com**

*Prime Therapeutics is an independent company that provides pharmacy benefits management services

FEATURES OF MEDICAREBLUE RX

MedicareBlue Values Program*

- Program includes discounts on a variety of products and services such as:
  - Vision exams, eyewear and vision laser surgery
  - Hearing exams and hearing aids

*The products and services described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the MedicareBlue Rx grievance process.

OTHER PRESCRIPTION DRUG COVERAGE

- Beneficiaries with Veterans Affairs (VA) prescription drug benefits, or those enrolled in prescription drug coverage through an employer or union group plan should review their options carefully
  - Drugs covered by the VA are not eligible for additional coverage under Medicare Part D plans
  - Group members need to determine whether their current coverage is creditable (employers are required to provide this notification) and whether enrollment into a Part D plan will negatively impact their group benefits
- Beneficiaries with other prescription drug benefits should be encouraged to talk with their plan administrator before making a Part D enrollment decision

LATE ENROLLMENT PENALTY (LEP)

- Beneficiaries without creditable coverage who do not enroll in Medicare Part D when first eligible may be subject to a Late Enrollment Penalty (LEP) charge
  - Creditable prescription coverage is that which is identified as at least as good as, or better than, standard Part D benefits
    - VA and employer or union group benefits are usually creditable. Go to Medicare.gov for additional information on creditable coverage
  - LEP is 1% for each month without creditable coverage and is based on the national premium average at the time of enrollment
    - In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage
  - CMS will determine the penalty during the approval process and will notify MedicareBlue Rx of the penalty amount to be applied to the premium
  - Penalty will not apply for individuals with creditable coverage or members who are eligible for LIS

LOW INCOME SUBSIDY (LIS)

- Members eligible for LIS benefits who enroll in MedicareBlue Rx have access to our formulary and pharmacy network
- LIS members may be eligible for reduced premiums, deductibles, coinsurances and/or copays
  - Beneficiaries with limited income and resources are encouraged to contact the following for more information and assistance to determine if they qualify for extra help
    - Contact the local Social Security office or call Social Security at **1-800-772-1213**
    - Contact the local Medicaid office
    - Apply online at online at **socialsecurity.gov/prescriptionhelp**
    - Call 1**-800-Medicare**

DETERMINING PRODUCT SUITABILITY

- When determining product suitability, sales persons must review a beneficiary's current coverage to determine:
  - Suitability of a plan change
  - Current carrier disenrollment requirements (can vary depending upon if Medigap, commercial, Medicare, etc.)
  - The impact a new prescription drug plan may have on the other coverage
  - Whether coordination of other health care benefits needs to be considered

- This is especially important when a beneficiary is enrolled in an employer or union group health plan

CONSIDERATIONS RELATED TO OTHER COVERAGE

- Medicare beneficiaries may be enrolled in only one Medicare Advantage (MA) plan and only one Part D plan at a time
  - Beneficiary may not be simultaneously enrolled in a PDP and a MA plan except for a MA Private-Fee-For-Service plan that does not offer the Part D benefit, a Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority
- Medicare health plans include:
  - MA or MA-PD plans
  - PDP plans
  - Cost plans (with or without Part D)
- Generally, enrollment into a new PDP will result in disenrollment from other Medicare health plan coverage which includes Part D (PDP, MA-PD, or Cost-PD)
  - Beneficiaries currently enrolled in a non-Medicare prescription drug or health plan (i.e. Medigap) must contact their current carrier to:
    - Determine the impact of enrollment in new coverage on their current coverage (e.g. inability to re-enroll, duplication of benefits, etc.), and;
    - Get information on the required steps to disenroll from all or part of the current coverage

PART D ENROLLMENT AND DISENROLLMENT PERIODS

- In order for a Plan Sponsor to accept a request for enrollment or disenrollment, it must be made during a valid enrollment period

- There are three periods in which an individual may enroll in and/or disenroll from a PDP:
  - Initial Enrollment Period for Part D (IEP for Part D)
  - Annual Election Period (AEP)
  - Special Enrollment Periods (SEP)

PART D ENROLLMENT AND DISENROLLMENT PERIODS

- The last enrollment or disenrollment choice made during an enrollment period, determined by the date a request was received by the plan, will be the choice that becomes effective
  - Note that newly-eligible beneficiaries have two enrollment periods that sometimes coincide, IEP and AEP
    - In this situation, it is important to understand which election period and effective date the beneficiary wants, and to check the appropriate enrollment period on the enrollment application

ENROLLMENT REQUIREMENTS FOR PART D PRODUCTS

- Once the suitability of a new plan is determined, and the beneficiary's eligibility and election period determination are verified, the enrollment process can begin

- Before we cover the various enrollment steps and describe the enrollment options available, let's review CMS requirements and guidelines related to the beneficiary's election of a plan option

ENROLLMENT STATEMENTS AND NOTICES

- Beneficiary is responsible for reviewing statements and notices on the enrollment form
- Sales representative must answer all beneficiary questions about these statements (and the plan) before requesting a signature or submitting an enrollment form
- An “authorized representative” is someone with a legal designation to act on behalf of the beneficiary such as power of attorney or legal guardianship
  - Sales representatives are not considered “authorized representatives” and may not complete this part of an enrollment form

BENEFICIARY SIGNATURE

- A beneficiary's electronic or written signature on an enrollment form is verifying:
  - His or her intent to enroll
  - The personal information provided is accurate and truthful
  - A plan option is elected
  - A billing option is selected
  - Understanding and acceptance of all statements and notices on the enrollment form
- Sales representatives must NOT sign and date an enrollment form until the enrollment form is complete, the enrollee signs, and the sales person is ready to submit the application
  - Doing so could adversely affect the enrollment process
  - May enter agent name, number and agency number (if applicable) on the application form prior to enrollee signature

TIMELY APPLICATION SUBMISSION

- CMS gives Plan Sponsors very short timeframes for processing enrollment applications and considers receipt of an application by an agent to be the plan receipt date, therefore:
  - Applications should be submitted immediately following receipt
  - Applications received 5 or more calendar days after the agent signature date will be considered untimely and will result in corrective action

ENROLLMENT PROCESS

Once suitability and enrollment eligibility has been determined, the steps in the enrollment process include:

1. Completion of enrollment form
2. Receipt of enrollment form by Plan Sponsor
3. Submission to CMS for approval (accretion)
4. CMS accretion
5. Member materials issued by Plan Sponsor upon notification of enrollment approval by CMS

The enrollment process is explained in more detail in the next several slides

ENROLLMENT OPTIONS

Online Enrollment

- **Online enrollment** via **YourMedicareSolutions.com** with client present during the enrollment submission
- **Paper to online enrollment**
  - Beneficiary grants sales representative permission for online submission (without beneficiary present) via checkbox on paper enrollment form
  - Original enrollment form and submission confirmation must be kept on file for current year plus 10 years (11 years total) and made available upon Blue Cross request
- Benefits of online enrollment:
  - Reduces errors and delays due to missing or incomplete information
  - Immediate receipt of enrollment requests without delays
  - Immediate confirmation of submission
  - Allows sales person and plan to meet CMS timelines for acknowledgement letters and outbound enrollment and verification (OEV) process

ENROLLMENT OPTIONS

Paper Enrollment

Paper enrollment forms should be submitted online whenever possible. Alternatives to online submission:

- Mail enrollment form via overnight mail
- Fax completed enrollment form

- Premium payments should NOT be included with the enrollment form
  - Premiums will be collected via the billing method the member selected, after CMS approval and the plan becomes effective
    - Inform beneficiary that Electronic Funds Transfer (EFT) and Social Security/Railroad Retirement Board check deduction methods may take two months or more to begin, therefore a paper bill will be sent in the interim
    - Inform beneficiary that this is separate from other EFT transactions (such as EFT for a Medigap or Cost plan)

TELEPHONIC ENROLLMENT BY A BENEFICIARY

- Plan Sponsors may accept enrollment requests via an incoming telephone call from a beneficiary to complete an enrollment
  - Telephonic enrollment request must be entirely effectuated by the beneficiary or his/her authorized representative
  - Sales persons must not be physically present or present on the phone at the time of this call
  - Sales persons may be on the call with the pre-enrollment call center and the member to give agent identifier information, but then must disconnect from the call prior to the enrollment of the member
- The beneficiary must have received and reviewed the enrollment materials
- Telephonic enrollments must be recorded and completed through contracted vendor using a CMS-compliant script to ensure that beneficiaries:
  - Understand they are being recorded
  - Are attesting to the accuracy of required elements
  - Understand they are completing an enrollment
  - Are attesting to their intent to enroll
- Collection of financial information is prohibited at any time during the call

APPLICATION DO'S FOR SALES PERSONS

- Do make sure to understand marketing rules, including what a Scope of Appointment (SOA) is, when a SOA form is required, and how to properly complete the form
- Do put your Agent number on all enrollment forms mailed or left with enrollee to ensure receipt of commissions
- Do submit applications online via **YourMedicareSolutions.com**
- Do submit applications immediately upon receipt in order to remain compliant and avoid corrective action
- Do keep original applications, SOA forms and a copy of all confirmation sheets (fax, online, overnight) for the current year plus 10 years (11 years total) for verification
- Do include beneficiary's best telephone number on application so Plan Sponsor can contact beneficiary for the OEV call or if there is missing or incomplete information

APPLICATION DON'TS FOR SALES PERSONS

- Do not mail paper enrollment forms via the United States Postal Service (USPS) regular mail
  - Can only be entered and submitted online with beneficiary's permission, faxed or sent via overnight mail
- Do not sign and date the enrollment form BEFORE the enrollee
- Do not hold an enrollment form for a future effective date
  - Form must be submitted immediately upon receipt from the enrollee
- Do not hold and batch enrollment forms
  - Form must be submitted immediately upon receipt from the enrollee
- Do not submit an enrollment form to your brokerage or agency to batch and submit
  - Form must be submitted immediately upon receipt from the enrollee

ENROLLMENT FORM APPLICATION DATE

- CMS defines the enrollment form “application date” as the date that the enrollment form is received by the Plan Sponsor
  - Receipt by the sales person is considered receipt by the Plan Sponsor
- Receipt of the application by the plan is considered to be:
  - The date the sales person signs and dates the enrollment form;
  - The **earlier** of the date stamp and/or signature date of the sales person or the agency; or
  - If there is no sales person signature on enrollment form, the Plan Sponsor’s mailroom receipt date
- Online enrollments are electronically date-stamped to identify the application date
- Paper enrollment forms mailed by a beneficiary directly to the processing centers are date stamped the day they are received
  - Note if sales person’s signature date is present, it is used as application receipt date

WHAT HAPPENS WHEN BLUE CROSS RECEIVES AN ENROLLMENT FORM?

1. The plan reviews the enrollment form to ensure that all required data is included and submits the request to CMS for approval
2. OEV call(s) are made to the beneficiary within 15 calendar days of the enrollment receipt date to verify the beneficiary understands the plan rules
    - Three call attempts are made, and if no contact after second call attempt a letter is sent
    - Sales representative should advise beneficiary of the process and explain that it is a CMS requirement
3. Once the plan has submitted the enrollment form to CMS, an acknowledgment letter, ID cards and member materials are generated and mailed
4. A confirmation letter is sent to the applicant informing them of final CMS acceptance or denial
    - CMS typically notifies the plan of enrollee eligibility within 14 days
    - Agency managers will receive reports of CMS accepted enrollments

MISSING OR INCOMPLETE INFORMATION ON ENROLLMENT FORMS

- Enrollment forms with missing or incomplete information cannot be sent to CMS for approval
  - The beneficiary will be contacted via telephone or in writing within 10 calendar days of the application receipt date to request missing information or clarifying documentation
  - If the missing information is received within the allowable timeframe, and the election is deemed “complete,” the plan will forward the election to CMS
  - If the missing information is not received within the allowable timeframe, the enrollment request will be denied
- Note: The OEV process is not delayed due to missing or incomplete information

MISSING OR INCOMPLETE INFORMATION ON ENROLLMENT FORMS

- For Annual Enrollment Period (AEP) enrollment requests, additional documentation must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later)

- For all other enrollment periods, additional documentation must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later)

INCOMPLETE ENROLLMENT FORMS

Common errors that will delay processing and may impact the effective date include:

1. Not using applicant's legal name as identified by the Social Security Administration
2. Missing or incorrect date of birth
3. Missing, incorrect, or incomplete Medicare HIC number
4. No plan option selected
5. Incomplete or missing information in Section C
6. Missing beneficiary signature (or signature of authorized legal representative)
7. Election period not identified

ENROLLMENT SUBMISSION TO CMS

- Submission to CMS for approval
  - Plan Sponsor must submit enrollment data to CMS within seven calendar days from receipt of the completed application for accretion

- CMS Accretion
  - CMS reviews the enrollment requests to verify that the beneficiary meets all CMS eligibility requirements and notifies the Plan Sponsor of approval or rejection

DENIAL OF BENEFICIARY'S ELECTION

- The Plan Sponsor may deny elections based on:
  - Missing or clarifying information not being provided within the required timeframe
  - Determination of ineligibility, including:
    - Beneficiary does not reside in service area
    - Beneficiary does not have a valid election period
    - Beneficiary has outstanding premium balance with Plan Sponsor and fails to become current prior to submitting the new enrollment request
- Under these circumstances, the Plan Sponsor must provide notice of denial to the beneficiary, including the reason for denial, within 10 calendar days of this determination
  - Denial of an enrollment means the enrollment request was not submitted to CMS because the Plan Sponsor identified that the election was not valid

CMS ENROLLMENT APPROVAL

- Member materials issued upon approval by CMS
  - The Plan Sponsor must mail the beneficiary notification of CMS' response within 10 calendar days
  - A member ID card will arrive and the member may use this card for prescription purchases beginning on the effective date
  - Additional member information will arrive separately which includes important plan information such as the Evidence of Coverage (EOC)
    - EOC can also be accessed at **YourMedicareSolutions.com**

DISENROLLMENT FROM PART D PLANS

- In general, once a plan option has been elected, the member is “locked in” to the chosen plan for the remainder of the plan year (calendar year)
- Generally, enrollment into a Medicare drug plan during a valid enrollment period will automatically disenroll the beneficiary from another Medicare health plan that includes Part D coverage (PDP, MA-PD, or Cost-PD)
  - Submission of a disenrollment request could exhaust the beneficiary’s election period and adversely affect enrollment into a new plan
  - Submission of an enrollment into a PDP, when the member is enrolled in a MA-PD or Cost-PD, will result in the enrollee returning to Original Medicare for non-Part D coverage

DISENROLLMENT FROM PART D PLANS

- While most disenrollments occur as the result of enrollment into another Medicare health plan, there are limited instances where a beneficiary may request to disenroll:
  - Electing to disenroll during the Annual Enrollment Period (AEP) without electing another Medicare health plan option
  - Newly eligible for Veteran's Administration (VA) prescription drug benefits
  - Newly eligible for group or union health benefits
  - Determination of dual-eligibility or loss of dual-eligibility
  - Permanent residence change out of service area or into an institution (e.g. long-term care facility)

DISENROLLMENT FROM PART D PLANS

- Members who would like information on how to disenroll from a Part D plan may:
  - Call the Customer Service phone number listed on the back of the ID card or the number listed in the EOC
  - Find information in the Medicare & You handbook
  - Contact Medicare at 1-800-MEDICARE

- When there is no associated enrollment into a new Medicare health plan, all disenrollment requests must be submitted in writing and signed

COURSE SUMMARY
MEDICAREBLUE RX PRODUCT

- MedicareBlue Rx is offered by the regional plans, a group of six Blue Cross and Blue Shield plans across a 7-state region
- MedicareBlue Rx includes a nationwide network of pharmacies and a large prescription drug formulary to help control prescription drug costs for members
- MedicareBlue Rx may not be suitable for individuals enrolled in employer or union group benefits or other types of creditable prescription drug coverage
  - Beneficiaries should be encouraged to evaluate their current coverage to make an appropriate enrollment decision

COURSE SUMMARY: ASSESSING SUITABILITY

- Sales representatives assisting beneficiaries with submission of an enrollment form must:
  - Determine if the beneficiary is enrolled in other medical or prescription drug coverage AND
  - Determine the impact on the current plan by enrollment in a Part D plan

- Product advantages and limitations should also be discussed to assist beneficiaries with selecting the product that best suits their needs

COURSE SUMMARY: ENROLLMENT OPTIONS

- Sales representatives assisting beneficiaries with enrollment need to utilize one of the following options to expedite receipt of a complete enrollment request and reduce errors:
  - Online enrollment via **YourMedicareSolutions.com** with beneficiary present
  - Paper to online enrollment with beneficiary's permission for sales person to enter and submit application online without beneficiary present
  - Paper via overnight mail or fax
- Applications must be submitted immediately upon receipt
  - Do not mail paper enrollment forms via USPS regular mail

COURSE SUMMARY: MEDICARE PART D ENROLLMENT AND DISENROLLMENT

- Generally, disenrollment from one Medicare health plan that includes Part D occurs as the result of a valid enrollment into another Medicare health plan with Part D, so a disenrollment request should not be submitted
- Opportunities to submit a request to disenroll, without enrolling in another plan are limited, but may include:
  - Electing to disenroll during the Annual Enrollment Period without electing another Medicare health plan option
  - Newly eligible for Veteran's Administration (VA) prescription drug benefits
  - Newly eligible for group or union health benefits
  - Determination of dual-eligibility or loss of dual-eligibility
  - Permanent residence change out of service area or into an institution (e.g. long-term care facility)
- When there is no associated enrollment into a new Medicare health plan, all disenrollment requests must be submitted in writing and must be signed

For the health of all.