Plan Recap

We want to make sure you know what to expect with the new plan you've chosen.

✔ Please fill out this plan recap with your Licensed Sales Representative (if applicable).

Plan Information

Here are some details about your new plan.

My new plan is a: ☐ Medicare Advantage plan ☐ Medicare Advantage Special Needs plan

☐ Medicare Supplement Insurance (Medigap) plan ☐ Medicare Part D plan

The name of my new plan is: ____

My plan type is a (circle one): HMO HMO-POS LPPO RPPO PFFS

My plan type: ☐ Requires referrals ☐ Does not require referrals

☐ Includes a medical deductible unless the state or another third party pays it for me

☐ Does not include a medical deductible

My plan will provide: ☐ all my Medicare health coverage ☐ all my Medicare prescription drug coverage

I have purchased rider(s) as part of my plan: ☐ **Yes** ☐ **No** ☐ N/A

Proposed effective date: M M – D D – Y Y Y Y

I can cancel my enrollment in this plan before my coverage starts by calling Customer Service at ______________________________. Once my coverage starts, I may have to wait until I have a valid election period to make a plan change.

I must live in the plan's service area, which is ______________________________. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

I must (circle one) **have Medicaid / have a qualifying chronic condition / live in an institution or assisted living facility** to enroll in and/or remain enrolled in this plan. If the plan cannot verify my status, I understand that I may not be enrolled in or may be disenrolled from the plan.

Circle the correct answer: I should / should not have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time. (There is one exception: Medicare Advantage Private Fee-for-Service plans that do not include prescription drug coverage.)

Premium Information

What you need to know about paying your monthly plan premium.

My plan has a $ ____________ monthly premium that I must pay to stay in this plan. If I qualify for Extra Help, my premium may be less.* In addition, I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me.

If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.

*Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. To see if you qualify for Extra Help, call:

- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office

TEAR HERE

Network Information

Understanding your network is important.

Circle the correct answers: I need to get my care and services from **network / out-of-network** providers. I may have to pay the full cost for any care I get from **network / out-of-network** providers. But if I need emergency care, urgent care, or out-of-area dialysis, it will be covered wherever I need it.

List the doctors and hospitals you use in this table. Be sure to note whether they are part of the provider network and if they require referrals.

Provider Name	**Provider Type** (PCP/Specialist/ Hospital)	**Network** (Yes/No)	**Referral** (Yes/No)

Prescription Drug Coverage

Know how prescription drugs are covered on your plan.

My plan (circle one): **does / does not** have a prescription drug deductible.

If I have a deductible, the amount is $ ___________ and it applies to drugs in (check the answer(s)):

☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ Tier 5 or ☐ ALL tiers

List the medications you use in this table. Be sure to note their tier level, whether there are any limits on the drug, and if the prescription drug deductible applies.

Medication	**Tier Level**[1]	**Has Limits**[2] (Yes/No)	**Deductible** (Yes/No)

TEAR HERE

[1]My actual out of pocket costs may vary based on: the drug stage I am in, my drug tier level, the pharmacy I use (retail/mail-order), and if I have Extra Help.

[2]For medications that have limitations, I may need to contact the plan before I can fill my prescription. I can discuss alternatives by calling customer service to learn what other drugs might be on the drug list and by talking with my doctor or pharmacist.

I have the option to access my plan documents, such as Explanation of Benefits (EOB), electronically.

☐ I have opted to access documents electronically.

☐ I have not opted to access documents electronically at this time, but can contact the plan in the future to activate this option.

☐ I have provided an email address to provide the plan with various ways to reach me regarding important information.

☐ I do not have an email address; should I get one in the future, I can provide it to the plan to provide other ways to reach me with important information.

Contact your Licensed Sales Representative. If I have questions about my plan, I will call my Licensed Sales Representative, ______________________________ at ______________________ or Customer Service at ______________________.