OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA July CE Medicare & Medicare Advantage SEPs workbook

July, 2025

Statewide Health Insurance Benefits Advisors (SHIBA)

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Message from the SHIBA CTC

Dear Volunteers,

As the curriculum & training coordinator (CTC), I deeply value your input in shaping effective training materials. Your feedback is crucial as we strive to refine and enhance resources to better support you in your role as Medicare counselors. This workbook is designed to build your skills and knowledge through case scenarios and activities that encourage reflection and discussion. You are welcome to focus on the sections most relevant to your experience and expertise—there's no need to study all the material. Please take time to engage with the parts that interest you, jot down your insights, and share your thoughts during our sessions.
Your dedication to learning makes a meaningful difference in the lives of beneficiaries. Thank you for your commitment and for being an integral part of our team. I look forward to hearing your feedback and suggestions!

Elena Garrison
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Learning objective

By the end of this session, participants will be able to effectively assist a beneficiary who qualifies for a Special Enrollment Period (SEP) due to loss of employer coverage. They will be able to explain Medicare coverage options, including Medicare Advantage (MA) plan network restrictions, provider choice and referral requirements, cost implications, and available enrollment options with associated deadlines.

Counseling case preparation

Learning objective

To improve counselor's skills and ensure that a beneficiary has the necessary information and tools to actively participate and make informed decision about their healthcare coverage.

Case: Jean – Retiring and Choosing Between Medicare Options

- Age: 68
- Retiring next month & losing employer group health coverage
- Enrolled in Part A at age 65, doesn't have Part B

Counseling session preparation

Question	**Answer**
What information do you need to convey?	
What resources will you use?	

Session transcript

Counselor:
Hello, is this Jean?

Client:
Yes, speaking.

Counselor:
Hi Jean! My name is Lisa. I'm a certified volunteer counselor with SHIBA—that stands for Statewide Health Insurance Benefits Advisors. We offer free and unbiased help with Medicare.

I understand you're planning to retire soon and have questions about signing up for Medicare Part B and exploring your Medicare coverage options. Does that sound right?

Client:
Yes, exactly. I'm retiring next month, and I'm losing my employer coverage.

Counselor:
Thanks for confirming. Before we begin, I'd like to ask just a few quick questions. This helps me make sure I give you information that's specific to your situation—like what plans are available in your area, and whether you might qualify for programs to help lower your Medicare costs.

Is that alright?

Client:

Sure

Counselor:

First—what's your ZIP code?

Client:

98512

Counselor:

Thank you. That helps me see which Medicare Advantage and Part D plans are available to you.

Next—just to double-check, how old are you?

Client:

I am 68.

Counselor:

Perfect—that confirms you're eligible for full Medicare enrollment.

And one more thing:
Would you be comfortable sharing a rough estimate of your monthly or annual income**?**
This helps me check if you might qualify for programs like Extra Help for drug coverage
or a Medicare Savings Program, which could help pay your Part B premium.

Client:

Yes.

Counselor:

Will your monthly income—either now or after retirement—be below $2,000 for you alone or below $2,500 for you and your spouse?

Client:

No, it's higher than that.

Counselor:

Got it, thank you. Just something to keep in mind—if your income ever changes in the future, you might qualify for one of those programs. We'd be happy to help you explore those options if needed later on.

Let me just ask a few more questions to make sure we're on the right track. Is your current insurance through your employer, based on active employment?

Client:
Yes, I've been working and had coverage through my job.

Counselor:
Great. And does your employer have 20 or more employees?

Client:
Yes, way over 100.

Counselor:
Perfect—that confirms your coverage is considered "creditable," which means you won't face any late penalties for enrolling in Medicare now.

Was your plan high-deductible? And did you contribute to a Health Savings Account after enrolling in Medicare Part A?

Client:
No, it isn't high-deductible, I stopped contributing to my HSA when I signed up for Part A.

Counselor:
That's great. You've done everything correctly so far.

Counselor:
Because you're retiring and losing your employer coverage, you now qualify for a Special Enrollment Period, or SEP. This allows you to enroll in Part B without a penalty. That SEP lasts for 8 months after your employer coverage ends.

Now, if you're also looking at a Medicare Advantage plan or a stand-alone Part D prescription drug plan, those have a tighter window. You'll have 2 full

months after your employer coverage ends to sign up for either of those.

Client:
Okay... I've heard of Medicare Advantage but not about Part D plan, but honestly. I'm kind of confused by all these plans. I don't really understand what the difference is or which one I need.

Counselor:
That's a completely normal reaction—Medicare can feel overwhelming at first. There's a lot of information out there, and not all of it is clear.

Let me walk you through your two main Medicare coverage paths step-by-step. Once we break it down, it usually starts to make a lot more sense.

Counselor:
Now that you're getting Part B, you'll have two main coverage paths to choose from:
Original Medicare and Medicare Advantage.

Let's start with Original Medicare.

It includes:

- Part A for hospital care. This is what you got when you signed up for Part A.
- Part B for doctor visits and outpatient services. This is what you get as soon as you sign up for part B.

You'd pay the standard Part B premium—about $185 per month in 2025. For most services, Medicare pays 80%, and you pay the remaining 20%.

You can also:

- Add a Part D plan for prescription drug coverage
- And you can choose a Medigap plan to help with out-of-pocket costs like deductibles and coinsurance, with those 20% that Medicare doesn't cover. Original Medicare does not include an out-of-pocket limit, so many people get Medigap for financial protection.

- The big plus—you can go to any doctor or hospital in the U.S. that accepts Medicare. No networks. No prior authorization to see specialists.

When it comes to the timeline, you have two timelines to pay attention to:

- 2 months to enroll in a Part D plan
- 6 months to apply for a Medigap plan with guaranteed acceptance

Though for uninterrupted coverage, applying right away is best.

Counselor:
Your second option is a Medicare Advantage plan, also called Part C. These are offered by private insurance companies and combine:

- Part A
- Part B
- And usually Part D

Some plans include extra benefits like vision, dental, or hearing. You'd still pay the Part B premium, but the plan premiums can be low—or even $0.

Medicare Advantage plans use provider networks—either HMOs or PPOs. Basically, MA plans generally require beneficiaries to receive most of their care from providers within the plan's network.

- These plans come with a built-in maximum out-of-pocket limit, which helps cap your yearly medical costs

And just like with Part D, you'd need to enroll within 2 months after your job coverage ends.

Client:
I think I'm leaning toward Medicare Advantage. It feels more familiar—kind of like what I have now.

Counselor:
That's a common feeling, especially for people coming from employer plans. Let's

walk through a few key questions to help you compare:

Do you prefer the freedom to see any doctor nationwide, or are you okay using a network of providers?

Client:
I'm used to networks, and I was fine with them.

Counselor:
Got it. Now let's talk briefly about the two types of MA plans:

Counselor:
HMO plans tend to have lower monthly costs, but you must:

- Stay in-network for most care
- Get referrals to see specialists

PPO plans give you more flexibility:

- You can see out-of-network providers, though you'll pay more
- No referrals needed for specialists
- But the premiums and copays can be higher

Also, both types require prior authorizations for certain services—like physical therapy or outpatient procedures.

Now, about cost limits:

- HMOs have one in-network maximum-out-of-pocket limit.
- PPOs have two: one for in-network, and another for combined in- and out-of-network costs.

Let's say your in-network MOOP is $6,000. If you only see in-network providers, that's your cap.
But if you go out-of-network, the combined limit might be $10,000. You'd need to hit that total before your plan covers 100% of costs for both.

Counselor:
Do you spend any time out of state?

Client:
Yes—I usually go to Oregon for a couple of months each winter to visit my daughter.

Counselor:
That's helpful to know. A PPO plan may work better for you, since it offers some out-of-network coverage while you're away.

Still, if nationwide flexibility is your priority, Original Medicare lets you see any provider that accepts Medicare—no networks or referrals required.

Counselor:
Do you want to keep your current primary care doctor or any specialists?

Client:
Yes, I'd really prefer to stay with them.

Counselor:
Then I recommend calling their office to:

- Ask which Medicare Advantage plans they accept
- And confirm whether they take Original Medicare

This will help narrow down your options.

Client:
I saw a commercial that mentioned a plan with a premium reduction—something about a giveback?

Counselor:
Yes, some Medicare Advantage plans offer a Part B premium giveback, which lowers the amount taken from your Social Security check.

But a few things to keep in mind that givebacks might not be as substantial as

you think they are:

- The amount varies widely—some are just a few dollars
- It's not offered in every plan or area
- And it can change every year during the Annual Enrollment Period

So while it's a nice benefit, it's important to look at the overall plan value—like the network, coverage, and copays—not just the giveback.

Counselor:
Are you comfortable using technology?

Client:
Yes, I am.

Counselor:
Great. I suggest visiting Medicare.gov and using the Plan Finder tool. It lets you:

- Compare plans in your area
- Check drug coverage and pharmacy networks
- View plan ratings
- And see which doctors and hospitals participate

Then you can visit the plan websites for details like giveback amounts and provider directories.

Counselor:
Would you like help comparing plans now?

Client:
No, I think I need some time to think it over.

Counselor:
Before we wrap up, let me quickly go over all your key deadlines—just to make sure everything's clear:

- Your Special Enrollment Period (SEP) for Part B lasts 8 months from when your employer coverage ends—but enrolling right away avoids any delay in starting coverage
- Your employer coverage ends June 30, so you have:
    - Until August 31 to enroll in a Medicare Advantage plan
    - If you choose to go with Original Medicare, you'd need to enroll in a stand-alone Part D prescription drug plan until August 31 as well.
    - You also have 6 months from the date your employer coverage ends to enroll in a Medigap plan with guaranteed issue rights
        - And if you want to avoid any delay due to preexisting condition rules, it's best to apply as soon as you get Part B.

Client:
Got it. Thanks for repeating that. I wrote this down.

Counselor:

So, your next steps are:

Enroll in Medicare Part B as soon as possible to avoid delays in coverage.

1. You can apply online at ssa.gov/medicare

    - You'll need to have your employer complete form CMS-L564 to verify your group health coverage.
    - Once completed, the form should be faxed or mailed to your local Social Security office.
    - If your employer is unable to complete the form, you can fill out Section B yourself to the best of your ability—just leave the signature line blank.
    - Be sure to also submit proof of your job-based health insurance, like a copy of an insurance card, pay stub with coverage info, or a letter from HR.

2. Call your doctor's office to:
    - And ask which Medicare Advantage plans they participate in
    - Also, just in case, confirm whether they accept Original Medicare

3. Compare your two main coverage paths—Original Medicare and Medicare Advantage.
4. Use Medicare.gov to:
    - Review available MA or Part D plans in your ZIP code
    - Check if your doctors, medications, and pharmacies are covered
    - View estimated costs and extra benefits
5. Visit individual plan websites for more detailed information—like Part B premium giveback amounts, referral policies, and network size
6. Keep track of the deadlines

Would you like me to email you these details?

Client:
Yes, that would be great.

Counselor:
Perfect. I'll send a resource packet that includes a summary of your options, a deadlines calendar, and step-by-step instructions for comparing plans online.

Thanks again for taking the time to talk today, Jean.
If you have any questions down the line, SHIBA is always here to help.

Client:
Thank you so much. I really appreciate it.

Counselor:
You're very welcome. Take care—and best of luck with your transition into retirement!

Counseling session activities

Listen to the counseling session or read its transcript and evaluate it.

What did they do well?	What can they do better next time?

STARS

Please Review the Beneficiary Contact Form (BCF) (see Appendix A) and highlight the counseling session-related fields.

Notes:

Signing Up for Medicare[1]

To enroll in Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance), clients must contact the **Social Security Administration (SSA)**. Depending on their situation, counselors can help identify the most appropriate and efficient way to enroll.

Note: Many clients ask why they can't simply contact Medicare to sign up. Counselors should clarify that enrollment in Parts A and B is handled by Social Security, not Medicare.

Enrollment Scenarios

1. The client is turning 65 and wants to sign up for both Part A and Part B (or Part A only):

Encourage the client to **apply online through Social Security**—this is typically the fastest and easiest method, and it allows them to apply for both Medicare and any financial assistance they may qualify for.

- The client will need to create a secure *my Social Security* account.
- Online application is available at www.ssa.gov.
- Counselors should ensure the client understands the available Medicare enrollment periods.

2. The client already has Part A and now wants to add Part B due to loss of job-based coverage:

The client may qualify for an 8-month **Special Enrollment Period (SEP)** and can apply online for Part B.

[1] https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b#:~:text=A%20person%20may%20be%20eligible%20if%20they,ends%20six%20months%20after%20the%20Medicaid%20termination.
https://medicareadvocacy.org/eligibility-enrollment/

- The client must have their employer complete form CMS-L564[2].
- The completed form should be faxed or mailed to their local Social Security office.
- If the employer is unable to complete the CMS-L564 form, the client should complete Section B to the best of their ability without signing it. They must also submit proof of job-based health insurance.
- Counselor should advise beneficiary to enroll either in the three months before, or in the actual month their employment ends to avoid any gaps in coverage.

3. The client missed their Initial Enrollment Period at age 65 and wants to enroll now:

The client may be eligible for a two-month **Special Enrollment Period due to exceptional circumstances**. This may include: employer error, living in an area impacted by disaster/emergency, losing Medicaid coverage, being released from incarceration and other exceptional circumstances.

- They should complete **Form CMS-10797**[3] and send it by fax or mail to their local Social Security office.
- An individual's request for this SEP will only be granted in conditions that are truly exceptional in nature and will not be used to grant individual's enrollment due to forgetfulness, lack of knowledge, or failure to make premium payments.
- Counselors should direct clients to SSA. SSA will determine when this SEP begins on a case-by-case basis. The SEP will end no less than 6 months after it begins. Medicare benefits will be effective the first day of the month following enrollment.

4. The client already has Part A and wants to add Part B during the General Enrollment Period (Jan 1 – Mar 31):

If no other enrollment period applies, the client may enroll during this time.

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[2] https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009718

[3] https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list/cms10797

- The client must complete **Form CMS-40B**[4] and send it by fax or mail to their local Social Security office.
- Counselors should confirm whether the client qualifies for other enrollment options before using this one, as this period may result in a **late enrollment penalty** and **delayed coverage**.

Counselor Corner: Helpful Links and Reminders

Ensure clients understand when and how they can enroll to avoid delays or penalties.

- **Forms:** Be familiar with the following forms CMS-40B, CMS-L564, and CMS-10797.
    - Application for Enrollment in Medicare Part B (CMS-40B) (PDF)
    - Request for Employment Information (CMS-L564) (PDF).
    - Application for Medicare Part A and B — Special Enrollment Period (Exceptional Conditions) (CMS-10797) (PDF).
- **Social Security Office Locator:** Help locate local offices and provide weblinks

[4] https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms017339

Special Enrollment Periods for Parts C and D

Individuals are limited in when and how often they can join, change, or leave a Medicare Advantage Plan or stand-alone Part D plan.

- They can enroll in a plan during their Initial Enrollment Period when they first qualify for Medicare.
- They can switch from one Medicare Advantage Plan to another, or return to Original Medicare with or without a Part D plan, during the Medicare Advantage Open Enrollment Period (MA OEP), which runs from January 1 to March 31 each year. This period is only available to those already enrolled in a Medicare Advantage Plan.
- They can change their health and/or drug coverage during Fall Open Enrollment, which takes place each year from October 15 to December 7.

Outside of these three periods, individuals can only change their MA or Part D coverage if they qualify for a Special Enrollment Period (SEP).

Special Enrollment Period (SEP)

The length of a Special Enrollment Period and the start date of new coverage depend on the specific situation that qualifies the individual for the SEP.

All SEPs are listed in the Appendix B. These SEPs allow changes to Medicare Advantage Plans, Medicare drug plans, or both. The rules are the same whether the person is in a stand-alone drug plan or a Medicare Advantage Plan that includes drug coverage.

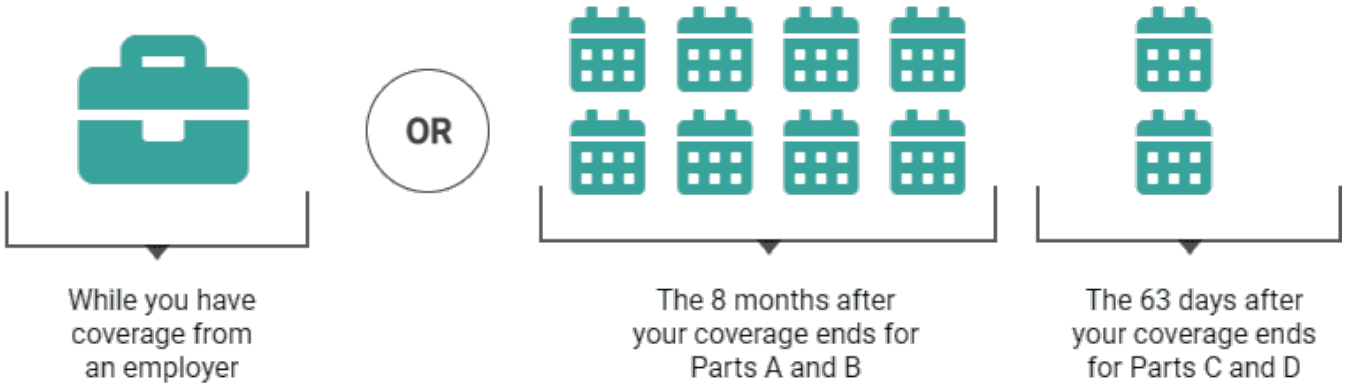
Case-related MA SEP

A beneficiary may have delayed enrollment because they had creditable health coverage through an employer, union, or a spouse's employer at the time of their 65th birthday.

- The SEP to enroll in a Medicare Advantage Plan lasts for 63 days after either the end of employer or union group health coverage, or the end of employment—whichever comes first.
- The SEP to enroll in a Part D plan also lasts for 63 days after the end of employer, union, or Veterans Administration (VA) coverage, or the end of employment—whichever comes first.

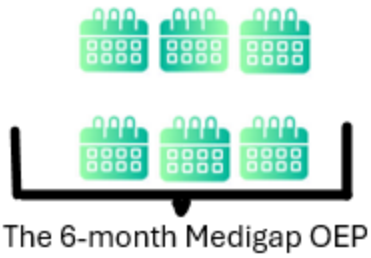
If a beneficiary delays enrollment in a Medicare Advantage Plan with Part D or a stand-alone Part D plan beyond the SEP window, they may have to pay a late enrollment penalty for Part D. This penalty continues for as long as the beneficiary has Part D coverage.

Case-related Special Enrollment Periods for Parts A, B, C and D



Case-related[5] Medigap Open Enrollment

For individuals who delay enrolling in Medicare Part B due to other coverage—such as employer-sponsored insurance—their six-month Medigap Open Enrollment Period starts the month they begin Medicare Part B, not when they turn 65.



During this six-month window:

- Companies cannot deny coverage, so called guaranteed issue right. Thus, Medigap insurance companies must offer coverage regardless of the applicant's current or past health conditions.

Medigap Open Enrollment Period: **Creditable coverage & preexisting conditions[6]**

- If the applicant has had at least three months of continuous prior health coverage (known as "creditable coverage") before applying, the insurance company cannot **delay coverage** or exclude benefits due to preexisting conditions.
    - For Medigap policies, certain types of prior health insurance coverage held within 63 days before obtaining a new policy can be used to shorten the waiting period for preexisting conditions. This prior coverage is referred to as *creditable coverage*[7].
- If the applicant has less than three months of continuous creditable coverage before applying, the insurance company may impose up to 90-day waiting period for coverage of preexisting conditions. However, any prior creditable coverage the person had must be applied to shorten or eliminate this waiting period.

[5] For all Medigap enrollment information, please see June CE

[6] **RCW 48.66.025** https://app.leg.wa.gov/RCW/default.aspx?cite=48.66.025

[7] See Appendix D for creditable coverage examples

Open Enrollment Period & creditable coverage summary

Applicant Situation	Can Be Denied a Medigap Policy?	Waiting Period for Preexisting Conditions?
Applied during Medigap Open Enrollment AND had 3+ months of creditable coverage prior to this	No	No
Applied during Medigap Open Enrollment AND had less than 3 months of creditable coverage prior to this	No	Yes — only for the gap in creditable coverage, up to 90 days

Compare Original Medicare & Medicare Advantage

When helping a beneficiary decide between Original Medicare and a Medicare Advantage Plan, counselors should consider the following key differences:

Doctor and Hospital Choice

Original Medicare	Medicare Advantage
Beneficiaries can see any doctor or go to any hospital in the U.S. that accepts Medicare.	Beneficiaries are usually limited to doctors and providers within the plan's network and service area for non-emergency care.
Referrals are generally not needed to see specialists.	Referrals to specialists may be required, depending on the plan.

Costs

Original Medicare	Medicare Advantage
For services covered under Part B, the beneficiary typically pays 20% of the Medicare-approved amount after meeting the deductible (coinsurance).	Out-of-pocket costs vary by plan and by service.
Beneficiaries pay the monthly Part B premium and, if enrolled, a separate premium for a Medicare drug plan (Part D).	Beneficiaries pay the Part B premium and may also pay an additional premium for the plan. Some plans have a $0 premium and may cover part or all of the Part B premium. Most plans include drug coverage (Part D).
There is no annual limit on out-of-	Plans include an annual out-of-pocket

Original Medicare	Medicare Advantage
pocket costs unless the beneficiary has supplemental coverage (e.g., Medigap, Medicaid, employer or retiree coverage).	maximum for Part A and Part B services. Once this limit is reached, covered services are free for the rest of the year.
Beneficiaries can buy a Medigap policy or use other coverage (such as from an employer or Medicaid) to help with out-of-pocket costs.	Medigap policies cannot be used with Medicare Advantage Plans.

Coverage

Original Medicare	Medicare Advantage
Covers most medically necessary services and supplies in hospitals, doctors' offices, and other healthcare settings. Does not typically cover routine physicals, eye exams, or most dental care.	Must cover all services covered under Original Medicare. Some plans may apply their own rules to determine medical necessity and may offer additional benefits not covered by Original Medicare.
Generally, no prior authorization is required for services.	Many services may require prior authorization from the plan.
Beneficiaries can enroll in a separate Medicare drug plan (Part D).	Most plans include Medicare drug coverage (Part D). In most cases, beneficiaries cannot enroll in a separate Part D plan.

Foreign Travel

Original Medicare	Medicare Advantage
Generally does not cover care outside the U.S., but Medigap may offer limited coverage for emergency care	Most plans do not cover care outside the U.S., though some may include emergency or urgent care coverage as an additional

Original Medicare	Medicare Advantage
abroad.	benefit.

Counselor Corner: Beneficiary at crossroads

Use the following questions to guide your conversation and help the beneficiary evaluate whether Original Medicare or a Medicare Advantage Plan (or comparing different MA Plans) meets their needs:

Coordination with Other Coverage

- Do you currently have other health coverage, like from an employer or retiree plan?

Providers, Hospitals, and Other Facilities

- Do you have a primary care provider (PCP) you want to continue seeing? Would you be comfortable selecting a new one if needed?
- If your current providers are not in the network, would you still want to see them? Are you okay with possibly paying more for those visits?

Access to Health Care

- Do you mostly receive care in a specific area, or do you travel often?
- Would you need coverage if you get care outside the plan's service area?
- Are you comfortable getting a referral from your PCP before seeing a specialist, if the plan requires it?
- Are you comfortable following any special rules or restrictions the plan might have for using those extra benefits?

Costs

- Are you familiar with what you'll pay each month for your coverage, such as premiums and copayments?

- Do you know what your deductible is—that is, how much you'll need to pay out of pocket before the plan starts covering services?
- Are you familiar with MA plan yearly out of pocket limit for medical care?
    - *(If considering a PPO)*: Do you know the difference between your in-network and out-of-network out-of-pocket limits?
- How would you feel about paying more to see providers or facilities outside the plan's network?

Benefits Beyond Original Medicare

- Are you looking for coverage for services that Original Medicare doesn't offer, like:
    - Dental care?
    - Vision care?
    - Hearing aids?

Prescription Drug Coverage

- Do you need a plan that includes outpatient prescription drug coverage?

Medicare Advantage basics

Medicare Advantage (Part C) offers an alternative to Original Medicare with different costs, networks, and coverage options.

Individuals enrolled in a Medicare Advantage (MA) Plan still have Medicare. This typically means they are responsible for paying the monthly premium for Part B, and a Part A premium if applicable.

MA Plans are required to provide at least the same benefits as Original Medicare. However, these plans may have different rules, costs, and restrictions that can affect how and when care is received.

Some MA Plans may also offer additional benefits not covered by Medicare, such as dental and vision care, caregiver counseling and training, and certain in-home support services like housekeeping. Since not all MA Plans include these extra benefits, it is important to check with the specific plan to understand what is covered.

Eligibility requirements to join a Medicare Advantage plan

- Must live in the plan's service area
- Must be enrolled in both Medicare Part A and Part B

Medicare Advantage: Plan types

Each Medicare Advantage Plan has its own network rules. A network includes doctors, hospitals, and facilities that have agreed to work with the plan. Some plans may require referrals to see specialists or may limit coverage if you go out of network.

Two common types of Medicare Advantage plans are:

- Preferred Provider Organization (PPO) plans.
- Health Maintenance Organization (HMO) and

There is also a less common HMO Point-of-Service (POS) option.

Preferred Provider Organization (PPO) plans

A type of Medicare Advantage plan where the client will pay less if they use providers in the plan's network. Clients do not need to select a primary care physician. Clients also can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Health Maintenance Organization (HMO)

A type of Medicare Advantage plan that usually limits coverage to care from doctors who work for or contract with the HMO. HMO plans require a person to select a primary care physician (PCP). An HMO may require the client to live or work in its service area to be eligible for coverage.

HMO plans generally won't cover out-of-network care except in an emergency, out-of-area urgent care, and temporary out-of-area dialysis.

Health Maintenance Organizations Point-of-Service (HMO-POS)

The Point-of-Service (POS) option is offered in some Health Maintenance Organization (HMO) plans. Most HMOs only cover care from in-network providers, except in case of emergency.

With an HMO-POS plan, an individual must choose a PCP, but they can use out of-network services at a higher cost, similar to a PPO plan.

The plan may require prior authorization for some healthcare services, meaning that a person must confirm coverage of intended treatment ahead of time. Medicare then produces a document stating that it will cover the services in line with the plan benefits and limits.

The POS portion and HMO parts of the plan have separate deductibles.

Key differences between HMO and PPO Medicare Advantage plans

Category	HMO (Health Maintenance Organization)	PPO (Preferred Provider Organization)
Network Structure	• Requires selection of a Primary Care Physician (PCP) within the plan's network • Referrals usually required to see specialists • Strict network restrictions; limited out-of-network coverage except in emergencies	• No PCP required • Referrals not needed for specialists • Greater flexibility to see out-of-network providers, but with higher costs
Coverage & Cost Sharing	• Lower, more predictable costs with copayments for in-network services • Plan sets MOOP (not exceeding $9,350 in 2025) • Part D MOOP is $2,000 • Limited out-of-network coverage, usually with higher cost-sharing	• Varying copayments and coinsurance; cost-sharing differs for in- and out-of-network services • Two MOOP limits: one for in-network, one for combined in/out-of-network (max $9,350 in 2025) • Part D MOOP is $2,000
Out-of-Network Coverage	• Generally not covered except in emergencies or urgent care situations	• Partial coverage available for out-of-network services, but usually at a higher cost
Geographic Coverage	• Focused on local or regional areas—best for individuals who stay in one place	• Broader network coverage—suitable for frequent travelers or those who spend time in multiple locations

Assisting beneficiaries: PPO or HMO

When assisting a beneficiary in choosing between a PPO and an HMO Medicare Advantage plan, it's important to gather information about their healthcare preferences, lifestyle, and priorities. Use the questions below and add your own questions to gather information and determine which plan option might be more suitable for them.

Provider preferences

- Do you have a preferred primary care physician (PCP) or specialist that you want to continue seeing?
- Are you willing to change your current healthcare providers to be in- network if needed?
- How important is the flexibility to see specialists without a referral?
- _____
- _____

Cost considerations

- Are you comfortable with a plan that generally has lower monthly premiums but higher out-of-pocket costs for each service? (HMO)
- Do you prefer a plan with higher monthly premiums but lower out-of- pocket costs and more flexibility in choosing healthcare providers? (PPO)
- Are you concerned about potential out-of-network costs?
- _____
- _____

Healthcare usage and needs

- How often do you visit healthcare providers and/or specialists?
- Are you generally healthy, or do you have chronic conditions that require ongoing specialist care?
- Do you anticipate needing medical services outside of your local area?
- _____
- _____

Referral and coordination of care

- Are you comfortable having a primary care physician (HMO) and obtaining referrals to see specialists, or do you prefer the flexibility to see specialists without referrals (PPO)?
- How important is it for you to have a coordinated approach to your healthcare with a primary care physician overseeing your care?
- _____
- _____

Network accessibility

- Do you plan to stay within a specific geographic area for most of the year, or do you travel frequently or live in multiple locations?
- How important is it for you to have access to a broader network of healthcare providers? (PPO)
- Are you willing to restrict your healthcare services to a more local network? (HMO)
- _____
- _____
- _____

Prescription drug coverage

- Are you aware of the prescription drug coverage offered by each plan and any associated costs?
- _____
- _____

- _____

Overall plan preferences

- What features of a Medicare Advantage plan are most important to you?
- Are there any specific concerns or preferences you have that would influence your choice between an HMO and a PPO?
- _____
- _____

Conclusion

PPO Plan: Offers more flexibility with provider choice and coverage for out-of-network services but generally comes with higher copays and out-of-pocket costs.

HMO Plan: Provides lower copays and maximum out-of-pocket costs but requires beneficiaries to stay within the network and obtain referrals for specialist care.

Counselor corner:

Each type of plan has advantages and disadvantages. It is important that a person consider which plan type would be best for their needs, location, and budget when looking for an HMO or PPO plan.

Not all Medicare Advantage plans—even plans of the same type—work the same way. So, it's also important to encourage beneficiaries to review the specific details of each plan's benefits, network, and costs before making a final decision.

If they have questions, encourage beneficiaries to contact plans directly for more information.

Services: medical necessity & prior authorization[2]

Medicare Advantage (MA) plans often require prior authorization for certain services, while Original Medicare typically does not. Prior authorization is a process where a plan requires doctors to get approval before certain treatments or medications are covered.

Prior authorization

Medicare Advantage

Medicare Advantage plans can use prior authorization to ensure patients meet the necessary guidelines.

However, they cannot use it for:

- Emergency services,
- Urgent care,
- Stabilization services, or
- Out-of-network services covered by MA PPO plans.

Purpose of prior authorization

It can only be used to confirm diagnoses or other medical criteria, ensure services or benefits are medically necessary, or verify that supplemental benefits are clinically appropriate. It should not delay or discourage care.

Duration of authorization

Once approved, a prior authorization for a treatment plan must be valid for as long as it's medically necessary to avoid care interruptions. The duration is

based on coverage criteria, the patient's medical history, and the provider's recommendation.

New enrollees must have a minimum 90-day transition period during which their new MA plan cannot require prior authorization for ongoing treatments, even if started with an out-of-network provider.

Original Medicare

While some specific services, like certain hospital outpatient procedures, may require it, the general rule is that Original Medicare does not need prior authorization.

Medical necessity

Medicare Advantage Plans

Medicare Advantage organizations must follow certain rules when deciding if a basic Medicare benefit is necessary. They must:

- Follow the medical necessity requirements stated in § 422.101(c).
- Consider the individual patient’s situation, including their medical history, doctor’s recommendations, and clinical notes.
- Adhere to the established Original Medicare coverage criteria.

If there are no clear Medicare rules for a particular benefit, MA organizations can use their own internal guidelines. These internal guidelines must be publicly accessible and based on the latest evidence from widely accepted treatment guidelines or clinical studies.

Original Medicare[8]

Original Medicare (Parts A and B) generally covers only medically necessary services and preventive care. This means services and supplies that are required to diagnose or treat an illness or injury, as well as preventive care to detect or prevent illness. Original Medicare does not cover routine physical exams, eye exams, dental care, hearing aids, or long-term care.

Medicare coverage is based on 3 main factors[9]:

- Federal and state laws.
- National coverage decisions Medicare makes.
- Local coverage decisions made by Medicare claims processing companies in each state. These companies decide if something is medically necessary and Medicare should cover it in their area.

[8] https://www.medicare.gov/providers-services/original-medicare

[9] https://www.cms.gov/medicare/coverage/determination-process#:~:text=Medicare%20coverage%20is%20limited%20to,Security%20Act%20(the%20Act).

Medicare Advantage & Part D plans notices

Notices for changes during the year[10]

Medicare Advantage and Part D plans may change provider networks or drug lists during the year. Beneficiaries should understand how these changes might affect their coverage and what kind of notice they can expect from the plan.

Network Changes

Beneficiaries enrolled in an MA Plan usually pay less when they use in-network providers.
However, in-network providers can leave a plan's network at any time. If a provider leaves, the plan must send a written notice at least 30 days in advance to any beneficiary who regularly sees that provider.

Mid-Year Formulary Changes

Beneficiaries may get drug coverage through a Medicare Advantage Plan or a stand-alone Part D plan. If a drug plan changes its list of covered drugs (formulary) during the year, beneficiaries have certain rights, depending on the reason for the change.

Maintenance changes

These changes include:

- Replacing a brand-name drug with a generic
- Moving a brand-name drug to a higher tier after adding a generic
- Adding restrictions, like prior authorization

[10] https://www.medicareinteractive.org/understanding-medicare/health-coverage-options/medicare-advantage-plan-overview/notices-that-medicare-advantage-and-part-d-plans-must-send-if-they-make-changes-during-the-year

- Removing a non-Part D drug that was mistakenly listed
- Making changes due to new clinical guidelines or FDA safety concerns

For **maintenance changes**, the plan must either give 60 days' notice or provide a 60-day transition refill.

Note: If the FDA declares a drug unsafe and removes it from the market, the plan can take it off the formulary right away. Plans should notify affected beneficiaries but are not required to give 60 days' notice in this case.

Other changes

Plans may make other changes that are not considered maintenance changes. If plan makes other formulary changes, and a beneficiary is already taking a drug that is being removed or changed, the plan must allow them to continue the medication for the rest of the year if it is still medically necessary. The plan must send a notice explaining this exemption from the change.

Plans must also send an updated formulary by mail to affected beneficiaries and update the information online and in print.

Explanation of Benefits (EOB)

After receiving services under a Medicare Advantage (MA) or Part D plan, clients typically receive an Explanation of Benefits (EOB) from their plan. EOBs are usually mailed once per month. EOB typically can be accessed online as well.

- An EOB is not a bill.

An EOB details the medical services or items received and explains how the MA plan processed the claim. It typically includes:

- Information about the services received
- The amount billed by the provider
- The amount the plan paid
- The amount client may owe (co-pays, deductibles, coinsurance)

While all Explanation of Benefits (EOBs) include the same type of information, the

format and layout can vary by plan.

If a service or item is not covered, beneficiaries should look for:

- Notes, comments, footnotes, or remarks, possibly on the following pages

The beneficiary should contact the plan if:

- There are questions about the EOB
- A service or item was not covered, and more information is needed

It's a good idea for beneficiaries to keep their EOBs. These documents may be needed later—for example, to correct a billing error or to support a medical deduction on a tax return.

Annual notices: ANOC & EOC

Annual Notice of Change (ANOC)

The Annual Notice of Change (ANOC) is a notice beneficiary receives from their Medicare Advantage or Part D plan in late September. The ANOC gives a summary of any changes in the plan's costs and coverage that will take effect January 1 of the next year. The ANOC is typically mailed or emailed with the plan's Evidence of Coverage (EOC), which is a more comprehensive list of the plan's costs and benefits for the upcoming year.

Evidence of Coverage (EOC)

Evidence of Coverage (EOC) is a document, outlining the details of coverage, costs, and benefits. It essentially serves as a legal contract between beneficiary and the plan. The EOC is typically sent out each year, usually in the fall, and is crucial for understanding plan's specifics.

Know your Rights when Shopping for a Medicare Advantage Plan

Medicare Advantage plans MUST:

- Only use marketing materials approved by CMS (Centers for Medicare & Medicaid Services), the federal agency with responsibility for Medicare and Medicaid
- Comply with the Do Not Call Registry
- Provide information in a professional manner
- Comply with state regulations on who may market plans

Medicare Advantage plans may NOT:

- Solicit Medicare beneficiaries door-to-door
- Send unsolicited e-mail
- Enroll people by phone – unless the person calls them
- Offer cash payments as an inducement to enroll
- Provide free gifts or meals when trying to sell plans
- Misrepresent or use high-pressure sales tactics

Knowing Medicare Advantage rights is one of the ways that beneficiaries can protect themselves and the Medicare program.

Agent/ Broker Behavior

PROHIBITED AGENT/BROKER BEHAVIOR for MA/PD PLANS	APPROPRIATE AGENT/BROKER BEHAVIOR for MA/PD PLANS
Cannot state that they are from Medicare or use words or symbols, including "Medicare" in a misleading manner. For example, they cannot state that they are approved, endorsed or authorized by Medicare, are calling on behalf of Medicare, or that Medicare asked them to call or see the beneficiary.	May call a beneficiary who has expressly given advanced permission (e.g., submission of a business reply card or scope of appointment (SOA)). Must use the CMS-approved third-party marketing organization disclaimer language in the first minute of the call. All calls must be recorded and stored.
May not market to beneficiaries door to door, including leaving materials at a beneficiary's doorstep.	May leave information at residence when scheduled appointment results in a no-show. May call a beneficiary they enrolled in a plan to discuss plan business, as well as discuss the availability of other plan options/types within the same parent organization. Disenrolled beneficiaries may also be called for quality improvement purposes.
Cannot send unsolicited text messages or leave voicemail messages.	May call or visit beneficiaries who attended a marketing/sales event if prior permission was given and documented.
May not approach beneficiaries unsolicited (e.g. door to door, walking up to cars, and approaching in parks and supermarkets)	May initiate a phone call to confirm an appointment. A second SOA must document additional product types of interest to the beneficiary that were not agreed to in advance.

Cannot conduct marketing/sales activities in healthcare settings except in common areas. Restricted areas include, but are not limited to exam rooms, hospital patient rooms, dialysis centers and pharmacy counter areas.	May conduct marketing/sales activities in common areas of healthcare settings. Appropriate common areas include waiting rooms, cafeterias, community or recreational rooms and conference rooms in hospitals, nursing homes, assisted living centers or other congregate housing.
Cannot make unsolicited calls, including contacting beneficiaries under the guise of selling a non- Medicare Advantage (MA) or non-Prescription Drug Plan (PDP) product.	Must secure a documented SOA. Marketing/sales events do not require documentation of beneficiary agreement.
Cannot provide meals at marketing /sales events.	Refreshments and snacks may be provided at marketing/ sales events.
Cannot conduct marketing or sales activities at an educational event including distributing marketing materials or enrollment forms.	May schedule appointments with beneficiaries who live in long-term care facilities and other congregate housing only upon request by the beneficiary.

Learning outcome

After participating in this session, how confident do you feel in your ability to:

1. Assist a beneficiary who qualifies for a Special Enrollment Period (SEP) due to loss of employer coverage?

☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Somewhat unconfident ☐ Not confident at all

2. Identify and explain enrollment options and associated deadlines for someone using a SEP?

☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Somewhat unconfident ☐ Not confident at all

3. Explain the different Medicare coverage options available to someone in this situation?

☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Somewhat unconfident ☐ Not confident at all

4. Describe the network restrictions of Medicare Advantage (MA) plans?

☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Somewhat unconfident ☐ Not confident at all

5. Explain provider choice and referral requirements under Medicare Advantage?

☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Somewhat unconfident ☐ Not confident at all

Appendix A: BCF

BENEFICIARY CONTACT FORM

*** Items marked with asterisk (*) indicate required fields**

Date of Contact *:

MIPPA *:	❑ Yes ❑ No		
Send to SMP:	❑ Yes ❑ No	**SIRS eFile ID: (*required if sending record to SMP)**	This field will automatically utilize the SIRS eFile ID entered on the Session Conducted By user's SHIP Team Member form

Counselor Information *

Session Conducted By* : _____

Partner Organization Affiliation* : _____

ZIP Code of Session Location *: _____

State of Session Location *: _____

County of Session Location *: _____

Beneficiary & Representative Name and Contact Information

Beneficiary First Name: _____ Representative First Name: _____

Beneficiary Last Name: _____ Representative Last Name: _____

Beneficiary Phone: (_____) -_____ -_____ Representative Phone: (_____) -_____ -_____

Beneficiary Email: _____ Representative Email: _____

Beneficiary Residence *

State of Bene Res. *: _____ Zip Code of Bene Res. *: _____ County of Bene Res. *: _____

How Did Beneficiary Learn About SHIP * [Select ONE]:

❑ CMS Outreach
❑ Congressional Office
❑ Employer
❑ Friend or Relative
❑ Health/Drug Plan
❑ Partner Agency
❑ Previous Contact
❑ SHIP Mailings
❑ SHIP Media
❑ SHIP Presentation
❑ SHIP TA Center
❑ SSA
❑ State Medicaid Agency
❑ State SHIP Website
❑ 1-800 Medicare
❑ Other
❑ Not Collected

Method of Contact * [Select ONE]:

❑ Phone Call
❑ Email
❑ Web based
❑ Postal Mail or Fax
❑ Face to Face at Counseling Location/ Event Site
❑ Face to Face at Bene Home/ Facility

Beneficiary Age Group * [Select ONE]:

❑ 64 or Younger
❑ 65 – 74
❑ 75 – 84
❑ 85 or Older
❑ Not Collected

Beneficiary Race * (multiple selections allowed):

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Not Collected

Beneficiary Language *:

English is Beneficiary's Primary Language ❑ Yes ❑ No

Receiving or Applying for Social Security Disability or Medicare Disability * [Select ONE]:

❑ Yes ❑ No

Have you or a family member ever served in the military? [Select ONE]:

❑ Yes ❑ No ❑ Unsure

Beneficiary Monthly Income * [Select ONE]:		Beneficiary Assets * [Select ONE]:	
❑ At or Above 150% FPL	❑ Not Collected	❑ Above LIS Asset Limits	❑ Not Collected
❑ Below 150% FPL		❑ Below LIS Asset Limits	

Which of the following best represents how you think of yourself? [Select ONE]:

- ❑ Lesbian or gay
- ❑ Straight, that is, not gay or lesbian
- ❑ Bisexual
- ❑ I use a different term _____
- ❑ Don't know
- ❑ Prefer not to answer

What is your current gender? [Select ONE]:		Do you consider yourself transgender? [Select ONE]:	
❑ Woman	❑ I use a different term _____	❑ Yes	❑ No
❑ Man		❑ Prefer not to answer	
❑ Non-binary	❑ Prefer not to answer		

Topics Discussed * (At least one Topic Discussed selection is required. Multiple selections allowed)

Original Medicare (Parts A & B)	❑ Accountable Care Organizations (ACOs) ❑ Appeals/Grievances ❑ Benefit Explanation ❑ Claims/Billing ❑ Conditional Enrollment ❑ Coordination of Benefits ❑ Eligibility ❑ Enrollment/Disenrollment ❑ Equitable Relief ❑ Fraud and Abuse ❑ Late Enrollment Penalty ❑ Provider Participation ❑ QIO/Quality of Care	**Medicare Part D**	❑ Appeals/Grievances ❑ Benefit Explanation ❑ Claims/Billing ❑ Disenrollment ❑ Eligibility/Screening ❑ Enrollment ❑ Fraud and Abuse ❑ Late Enrollment Penalty ❑ Marketing/Sales Complaints & Issues ❑ Pharmacy Network ❑ Plan Non-Renewal ❑ Plans Comparison
Medigap and Medicare Select	❑ Application Assistance ❑ Benefit Explanation ❑ Claims/Billing ❑ Complaints ❑ Eligibility/Screening ❑ Fraud and Abuse ❑ Guaranteed Issue Rights ❑ Plan Non-Renewal ❑ Plans Comparison	**Part D Low Income Subsidy (LIS/Extra Help)**	❑ Appeals/Grievances ❑ Application Assistance ❑ Application Submission ❑ Benefit Explanation ❑ Claims/Billing ❑ Eligibility/Screening ❑ LI NET/BAE
Medicare Advantage (MA and MA-PD)	❑ Appeals/Grievances ❑ Benefit Explanation ❑ Chronic Condition Special Needs Plans ❑ Claims/Billing ❑ Disenrollment ❑ Dual Eligible Special Needs Plans ❑ Eligibility/Screening ❑ Enrollment ❑ Fraud and Abuse ❑ Institutional Special Needs Plans ❑ Marketing/Sales Complaints & Issues ❑ Plan Non-Renewal ❑ Plans Comparison ❑ Provider Network ❑ QIO/Quality of Care	**Other Prescription Assistance**	❑ Manufacturer Programs ❑ Military Drug Benefits ❑ Prescription Discount Cards ❑ State Pharmaceutical Assistance Programs
		Other Insurance	❑ Union/Employer Plan ❑ Active Employer Health Benefits ❑ COBRA ❑ Indian Health Services ❑ Long Term Care (LTC) Insurance ❑ LTC Partnership ❑ Marketplace Transition to Medicare ❑ Other Health Insurance ❑ Retiree Employer Health Benefits ❑ Tricare For Life Health Benefits

❑ Supplemental Benefits

'lease explain:

_____

❑ Tricare Health Benefits
❑ VA/Veterans Health Benefits

Topics Discussed (cont'd) * (At least one Topic Discussed selection is required. Multiple selections allowed)

Medicaid

❑ Appeals/Grievances
❑ Benefit Explanation
❑ Claims/Billing
❑ Duals Demonstration
❑ Eligibility/Screening
❑ Fraud and Abuse
❑ Medicaid Application Assistance
❑ Medicaid Application Submission
❑ Medicaid Expansion (ACA) Transition to Medicare
❑ Medicaid Managed Care
❑ Medicaid Recertification
❑ Medicaid Spend Down
❑ Medicare Buy-In Coordination
❑ MSP Application Assistance
❑ MSP Application Submission
❑ MSP Recertification
❑ Program of All-Inclusive Care for the Elderly (PACE)
❑ Provider Participation
❑ QMB Improper Billing

Additional Topic Details

❑ Ambulance
❑ COVID-19
❑ Dental/Vision/Hearing
❑ DMEPOS
❑ ESRD
❑ Health Savings Account(s)
❑ Home Health Care
❑ Hospice
❑ Hospital
❑ Income Related Monthly Adjustment Amount
❑ Mail Order Prescription
❑ Medicare Card
❑ Medicare.gov Account
❑ Mental Health
❑ New to Medicare
❑ Opioids
❑ Physical Therapy
❑ Preventive Benefits
❑ Skilled Nursing Facility
❑ Substance Misuse/Fraud
❑ Telehealth
❑ Transportation

Total Time Spent on This Contact *	**Status**
____ Hours _____Minutes	❑ In Progress ❑ Completed

Special Use Fields

Original PDP/MA-PD Cost: _____

New PDP/MA-PD Cost: _____

Field 3: _____
Field 4: _____
Field 5: _____
Field 6: _____
Field 7: _____
Field 8: _____

Notes

Appendix B: SEPs for MA & Part D plan

The table on the following pages explains when a Special Enrollment Period may apply, how long each SEP lasts, and when the new coverage will begin.
If someone qualifies for multiple Special Enrollment Periods (SEPs) at the same time, choose the one that best fits their situation.

1. The individual has or loses creditable drug coverage through no fault of their own.
2. The individual chooses to change employer or union coverage from current or past employment.
3. The individual is institutionalized (e.g., in a nursing facility).
4. The individual is enrolled in a State Pharmaceutical Assistance Program (SPAP).
5. The individual has Extra Help, a Medicare Savings Program (MSP), and/or Medicaid.
6. The individual gains, loses, or has a change in eligibility for Medicaid, MSP, or Extra Help.
7. The individual wants to disenroll from their first Medicare Advantage Plan.
8. The individual enrolls in or disenrolls from PACE (Program of All-Inclusive Care for the Elderly).
9. The individual permanently moves to a new address.
10. The individual had issues with Medicare eligibility.
11. The individual becomes eligible for or loses eligibility for a Special Needs Plan (SNP).
12. The individual is passively enrolled into a Part D plan or a Dual-eligible SNP (D-SNP).
13. The individual experiences contract violations or enrollment errors.
14. The individual's plan no longer offers coverage.
15. The individual disenrolls from a Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period.

16. The individual qualifies for a new Part D Initial Enrollment Period upon turning 65.
17. The individual wants to enroll in a five-star Medicare Advantage or Part D plan.
18. The individual is enrolled in a consistently low-performing Medicare Advantage or Part D plan
19. The individual's Medicare Advantage Plan significantly reduces its network of providers.
20. The individual experiences an exceptional circumstance.
21. The individual enrolls in Part B or premium Part A using an exceptional circumstances SEP.

Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans[11]

1. The individual has or loses creditable drug coverage through no fault of their own.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual, through no fault of their own, loses prescription drug coverage that is considered creditable (i.e., coverage that is at least as good as Medicare Part D). This may also include situations where their existing coverage is reduced and no longer meets creditable standards. Examples include: • An employer stops offering prescription drug coverage. • A retiree plan changes its benefits and no longer meets Medicare's creditable coverage standard. Note: This SEP does *not* apply if the individual loses coverage due to non-payment of premiums or inability to afford the plan.	The SEP to join a Medicare Advantage Plan with drug coverage or a stand-alone Medicare Part D drug plan begins the month the individual is informed that their coverage will end or is no longer creditable. It lasts for: • 2 months after the loss of coverage, or • 2 months after receiving notice—whichever is *later*.	Coverage begins on the first day of the month after the individual submits a completed application. They may also request to delay the start of coverage for up to two months after the SEP ends.

[11] Information based on Medicare Rights Center publication: https://www.medicareinteractive.org/resources/special-enrollment-periods-for-medicare-advantage-and-part-d

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual wishes to disenroll from their current Medicare drug coverage in order to maintain or enroll in another type of creditable drug coverage—such as through the VA (Veterans Affairs), TRICARE, or a State Pharmaceutical Assistance Program (SPAP).	This SEP allows the individual to disenroll from a Medicare Advantage Plan with drug coverage or a stand-alone Medicare Part D plan at any time they become eligible to enroll in another form of creditable coverage.	Coverage under the new plan begins on the first day of the month after the plan receives the disenrollment request.

2. The individual chooses to change employer or union coverage from current or past employment.

(Regardless of Whether the Coverage is Creditable; Includes Current or Retiree Plans)

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual chooses to: • Enroll in or disenroll from an employer- or union-sponsored Medicare Advantage Plan or Medicare Part D drug plan; • Disenroll from a Medicare Advantage Plan or Part D plan in order to take employer or union health/drug coverage; • Disenroll from employer or union health or drug coverage (including COBRA). Examples include: • A person retires and decides to enroll in their former employer's retiree health plan instead of their Medicare Advantage Plan. • An individual with COBRA drug coverage decides to drop it and enroll in a Medicare Part D plan. • A person enrolled in a union-sponsored Medicare Advantage Plan chooses to switch to a different Medicare Advantage Plan.	The Special Enrollment Period (SEP) lasts for individuals who are enrolled in or joining an employer or union-sponsored plan. The SEP ends two months after the month in which employer or union coverage ends. Examples include: • If a person's employer coverage ends in May, their SEP continues through the end of July. • If someone decides to disenroll from union coverage in June, they have until the end of August to make changes to their Medicare plan.	Coverage may begin up to three months after the month a completed application is submitted. Examples include: • If an individual submits their application in April, coverage can begin as late as July 1. • If the employer/union plan administrator delays sending in the enrollment form, the Medicare plan may offer retroactive coverage back to the original submission date (e.g., if the form was submitted in March but processed in May, coverage may be retroactive to March 1).

3. The individual is institutionalized (e.g., in a nursing facility).

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual moves into, resides in, or moves out of a qualified institutional facility, including: • Skilled nursing facility (SNF) • Nursing home • Psychiatric hospital or unit • Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) • Rehabilitation hospital or unit • Long-term care hospital • Swing-bed hospital Examples include: • A person moves into a SNF after surgery. • An individual is discharged from a long-term psychiatric hospital.	Once institutionalized, the individual may enroll in, disenroll from, or switch their Medicare Advantage or Part D plan once per month. After they move out of the facility, they have two additional months to: • Join or leave a Medicare Advantage Plan or Part D plan • Switch to another plan • Return to Original Medicare if enrolled in a Medicare Advantage Plan	Coverage under the new plan begins on the first day of the month after submitting a completed application. However, coverage cannot begin before the individual becomes institutionalized or qualifies for an institutional SNP.
An individual qualifies for and wishes to enroll in an Institutional Special Needs Plan (I-SNP), which serves those requiring an institutional level of care. Examples include: • A long-term care facility resident who qualifies for an I-SNP. • A person at home receiving a level of care that meets state guidelines for institutional care.	The individual may enroll in or disenroll from an I-SNP at any time. There is no limit on how often this SEP can be used while the individual remains eligible.	Coverage begins the first day of the month after submitting a completed application.

4. The individual is enrolled in a State Pharmaceutical Assistance Program (SPAP).

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual is enrolled in a qualified State Pharmaceutical Assistance Program (SPAP)—a state-run program that helps residents with drug costs under Medicare. Examples include: • A person in New Jersey's PAAD program or another state's SPAP.	The SEP allows the individual to switch plans once per year at any time to: • Join a Medicare Advantage Plan or Part D plan • Change to another plan • Enroll in a plan that works with the SPAP Note: This SEP does not allow someone to drop Part D coverage. If the individual was auto enrolled by the SPAP, this SEP does not apply.	Coverage begins on the first day of the month after submitting a completed application.
An individual loses eligibility for SPAP, either because of income changes or no longer meeting residency or age requirements. Examples include: • A person no longer qualifies due to an increase in income. • A state changes its SPAP eligibility rules.	SEP begins in the month the SPAP eligibility is lost, or the individual is notified of the loss, whichever comes first. It continues for two months after the later of: • The month eligibility ends, or • The month they are notified of the loss	Coverage begins on the first day of the month after the individual submits a completed application.

5. The individual has Extra Help, a Medicare Savings Program (MSP), and/or Medicaid.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual with Extra Help (also called the Low-Income Subsidy) because they have Medicaid, and/or Medicare Savings Program (MSP), or Supplemental Security Income (SSI), or they applied for Extra Help.	This SEP allows the individual to join, disenroll from, or switch Part D plans once per month. Those with Medicare Advantage Plans can switch to Original Medicare with a stand-alone Part D plan once a month. Those with Original Medicare can change their stand-alone Part D plans. This SEP cannot be used to enroll in Medicare Advantage Plan with drug coverage.	Coverage begins on the first day of the month after application to the new plan is submitted. Additional notes: • If the individual does not choose a Part D plan, CMS will auto-enroll them into a benchmark plan, with coverage beginning the first day of the second month after Extra Help status is identified. • Until that plan begins, the individual is covered under the Limited Income NET (LINET) program through Humana. • Those who recently qualified for Extra Help and chose their own Medicare Part D plan, instead of waiting for automatic enrollment by CMS, may get coverage for any uncovered months through the LI NET program, run by Humana.
An individual has full Medicaid benefits.	Individuals with both Medicare and Medicaid get a SEP once per month to join an integrated Dual-eligible Special Needs Plan (D-SNP). This type of Medicare Advantage Plan combines Medicare and Medicaid benefits. To use this SEP, the person must also receive	Coverage begins on the first day of the month after application to the new plan is submitted.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
	their Medicaid benefits through a Medicaid Managed Care plan that is connected to the D-SNP.	

6. The individual gains, loses, or has a change in eligibility for Medicaid, MSP, or Extra Help.

An individual has a Special Enrollment Period (SEP) if…	**The SEP lasts…**	**The new coverage begins…**
An individual becomes newly eligible for Medicaid, a Medicare Savings Program (MSP), or Extra Help (the Low-Income Subsidy for Part D).	A one-time SEP is available for the individual to disenroll from or switch their Medicare Advantage Plan or Medicare Part D plan. This SEP lasts for three months after the date they are notified of their eligibility.	Coverage begins on the first day of the month after a completed application is submitted. Example: If the application is submitted on May 15, coverage begins June 1.
An individual loses eligibility for Medicaid, an MSP, or Extra Help. Examples include: • A person's income increases, making them no longer eligible for Extra Help. • An individual fails to renew their Medicaid coverage and is disenrolled.	A one-time SEP to disenroll from or switch plans is available for three months after the date the individual is notified of the loss of eligibility.	Coverage begins on the first day of the month after submitting a completed application. Example: If the person submits their new enrollment application in July, coverage begins August 1.
The individual's level of assistance changes, such as no longer qualifying for Medicaid but still qualifying for Extra Help. Examples include: • Medicaid coverage ends due to income increase, but the person still qualifies for a partial subsidy under Extra Help.	A one-time SEP to change Medicare Advantage or Part D plans is available for three months after notification of the change in eligibility.	The new coverage begins the first day of the month after a completed application is submitted.

7. The individual wants to disenroll from their first Medicare Advantage Plan.

An individual has a Special Enrollment Period (SEP) if…	**The SEP lasts…**	**The new coverage begins…**
An individual joined a Medicare Advantage Plan for the first time when they became eligible for Medicare Part B at age 65. Examples include: A person turns 65, joins a Medicare Advantage Plan, and decides within the first year that they prefer Original Medicare because they want to see providers not in their MA plan's network.	Individuals can leave their Medicare Advantage Plan at any time during the first 12 months of coverage and return to Original Medicare, with or without enrolling in a stand-alone Part D drug plan. Note: Under federal law, the person has a guaranteed issue right to purchase certain Medigap policies if they use this trial right. State laws may provide additional protections.	Depends on the situation.
An individual dropped a Medigap policy to enroll in a Medicare Advantage Plan for the first time and now wants to return to Original Medicare and re-enroll in Medigap. Example: •A retiree had Medigap Plan G, switched to a Medicare Advantage Plan for the first time, and decides to go back to Medigap within 12 months.	During the 12-month trial period after Medicare Advantage coverage begins, individuals can disenroll at any time and return to Original Medicare, with or without a stand-alone Part D drug plan.	Depends on the situation.

An individual dropped a Medigap policy to enroll in a Medicare Advantage Plan for the first time	The SEP is valid within 12 months of first enrolling in a Medicare private health plan.	Depends on the situation.

and now wants to return to Original Medicare and re-enroll in Medigap. Example: •A retiree had Medigap Plan G, switched to a Medicare Advantage Plan for the first time, and decides to go back to Medigap within 12 months.	The person may return to Original Medicare and buy a Medigap policy (if available) and join a stand-alone Medicare drug plan.	Coverage typically begins the first of the month after the new plan or Original Medicare enrollment is processed.

8. The individual enrolls in or disenrolls from PACE (Program of All-Inclusive Care for the Elderly).

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual chooses to disenroll from a Medicare Advantage Plan or a Medicare Part D plan to enroll in PACE (a program that provides comprehensive medical and social services to certain frail elderly individuals who are eligible for both Medicare and Medicaid). Examples include: • A person joins PACE for coordinated care and wants to leave their current Medicare Advantage Plan. • An enrollee switches from a Part D plan to PACE for integrated prescription benefits.	The SEP allows the individual to disenroll at any time from their Medicare Advantage or Part D plan to join PACE.	Depends upon the situation. Coverage under PACE generally begins on the date the individual is accepted into the program.
An individual disenrolls from PACE to join a Medicare Advantage Plan or Part D plan. Examples include: • A person leaves PACE due to relocation or preference and wishes to enroll in a stand-alone Part D plan or Medicare Advantage Plan.	The SEP to enroll in a new Medicare Advantage or Part D plan lasts up to two months after the effective date of disenrollment from PACE.	Depends upon the situation. Coverage may start on the first of the month after the new plan receives the completed enrollment application.

9. The individual permanently moves to a new address.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual permanently moves to a new address. This SEP applies if they: • Move out of their current Medicare Advantage or Part D plan's service area • Move within their current plan's service area but now have access to new plan options Examples include: • A person moves from one state to another where their current plan doesn't operate.	If the individual notifies their plan in advance, the SEP begins as early as the month before the move and lasts for two months after the month of the move. If the individual notifies their plan after the move, the SEP begins the month they notify the plan and lasts for two additional full months.	The individual may choose coverage to begin: • As early as the first day of the month of the move, if the application is submitted on time • Or, up to three months after the new plan receives the enrollment request Example: If the move is in April and the application is submitted in March, coverage could begin April 1.
If the plan is not notified about a move: • And Medicare learns the individual moved over 12 months ago, the plan will disenroll the individual at the end of that 12th month. SEP lasts from the 12th to the 14th month after the move. • If the move was over 6 months ago, the Medicare Advantage Plan will disenroll the individual at the end of month 12. SEP to switch begins in month 6 and ends in month 8. Example: • A person who moved in January but never	See above. Coverage begins based on when the new plan receives the application.	

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
reported it might be disenrolled by December, with SEP available in November through January.		
An individual returns to the U.S. after living abroad or is released from incarceration. Examples include: • A retiree moves back to the U.S. from overseas. • Someone is released from prison and becomes eligible for Medicare enrollment.	An SEP begins as early as the month before the move or release and lasts for two months after the move or release.	The individual may choose coverage to begin: • The first day of the month they moved (if submitted on time) • Or, up to three months after their new plan receives the enrollment application

10. The individual had issues with Medicare eligibility.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual receives retroactive enrollment into Medicare. Examples include: • Medicare determines someone was eligible earlier due to disability or delayed processing and sends a notice. • A person is awarded Medicare based on a Social Security appeal.	SEP to join a Medicare Advantage or Part D plan begins the month the individual receives notice of their entitlement and continues for two additional months.	Depends on the situation. Coverage start date will depend on how the retroactive enrollment aligns with the plan's processing timeline.
An individual does not have premium-free Part A and enrolls in Part B during the General Enrollment Period (January 1–March 31). Examples include: • A person aging into Medicare enrolls in Part B late and must pay a premium.	• SEP to join a Part D plan begins the date the individual applies for Part A or B and lasts for two months after enrollment. • SEP to join a Medicare Advantage Plan starts the date they apply and lasts for two months after they are enrolled in both Part A and B.	Coverage generally begins on the first day of the month afterthe plan receives the application. Example: If the Part B coverage begins in April and application is submitted in March, coverage may begin May 1.
An individual loses Part B but still has Part A and is involuntarily disenrolled from their Medicare Advantage Plan. Example: • A person's Part B premiums go unpaid and are terminated, which causes them to lose MA plan eligibility.	SEP to enroll in a Medicare Part D plan begins when the individual learns they lost Part B and continues for two additional months.	Coverage begins the month after the month the application is submitted. Example: Application submitted in July = coverage starts in August.

11. The individual becomes eligible for or loses eligibility for a Special Needs Plan (SNP).

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual becomes eligible to enroll in a Medicare Special Needs Plan (SNP). SNPs are Medicare Advantage Plans designed for people with specific needs, such as those with certain chronic conditions, who live in institutions, or who have both Medicare and Medicaid. Examples include: • A person with diabetes becomes eligible for a Chronic Condition SNP (C-SNP). • An individual newly enrolled in Medicaid becomes eligible for a Dual-Eligible SNP (D-SNP).	Individuals can leave their Medicare Advantage or Part D plan at any time to join a Special Needs Plan (SNP) if eligible. • Dual-eligible SNP: An SEP is available when someone first becomes eligible for Medicaid. • Institutional SNP: An SEP is available upon entering a qualifying facility. • Chronic Care SNP: Those with a qualifying chronic condition can join a matching SNP at any time. If another chronic condition is diagnosed, a new SEP allows enrollment in a different SNP that covers it.	Coverage begins on the first day of the month after the individual submits a completed application.
An individual loses eligibility to continue receiving coverage through their current SNP. SNPs are required to continue providing coverage for at least one month after the loss of eligibility and up to six months if it is likely the individual will requalify within that time. Examples include: • A dual-eligible beneficiary temporarily loses Medicaid.	The SEP to enroll in another Medicare Advantage or Part D plan begins the month the individual loses SNP eligibility and continues until: • Three months after the period of continued enrollment ends, or • When they enroll in a new plan—whichever comes first.	Coverage begins on the first day of the month after the new plan receives a completed application.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
• A chronic condition is no longer diagnosed or treated.		
An individual is enrolled in a Chronic Care SNP, but their healthcare provider fails to confirm the qualifying chronic condition by the end of the first month of enrollment. Example: • Someone enrolls in a SNP for congestive heart failure, but their provider does not submit documentation of the diagnosis by the plan deadline.	The SEP to switch to another Medicare Advantage or Part D plan begins in the month the plan notifies the individual they do not meet the eligibility criteria and ends: • Two full months after the month of notification, or • When they enroll in a new plan—whichever comes first.	Coverage begins on the first day of the month after the completed application is submitted.

12. The individual is passively enrolled into a Part D plan or a Dual-eligible SNP (D-SNP).

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
The Centers for Medicare & Medicaid Services (CMS) automatically enrolls an individual in a Medicare Part D plan after identifying their eligibility for Extra Help (also known as the Low-Income Subsidy). Examples include: • A person is newly approved for Medicaid or Supplemental Security Income (SSI), and CMS places them in a benchmark Part D plan. • Someone who had employer drug coverage loses it and becomes eligible for Extra Help; CMS enrolls them into a basic Part D plan.	The SEP to switch to another Medicare Part D or Medicare Advantage Plan with drug coverage begins after the later of: • The notification of enrollment, or • The effective date of the new plan. The SEP lasts for three months.	Coverage under the new plan begins on the first day of the month after the individual submits a completed application.
CMS auto-enrolls an individual in a new Dual-Eligible Special Needs Plan (D-SNP) after their previous D-SNP ends. Examples include: • A person's original D-SNP ends due to a plan exit or eligibility change, and CMS places them into a new D-SNP serving their area. • A dual-eligible individual moves to a new county and is auto-enrolled in a local D-SNP.	The SEP to switch to a different D-SNP, Medicare Advantage Plan, or return to Original Medicare with or without a Part D plan begins after the later of: • The notification of enrollment, or • The effective date of the new D-SNP. The SEP lasts for three months.	Coverage under the new plan begins on the first day of the month after the completed application is submitted.

13. The individual experiences contract violations or enrollment errors.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
CMS determines that a Medicare Advantage Plan or Part D plan violated a material provision of its contract, such as: • Failing to provide benefits on time • Not meeting required quality standards • Using misleading marketing tactics to encourage enrollment Examples include: • A plan representative promises a specific drug will be covered when it is not. • A plan delays pre-approved treatments repeatedly. • A plan misrepresents its in-network providers.	The SEP begins once the CMS Regional Office confirms the violation. The individual may: • Switch to another Medicare Advantage or Part D plan • Or disenroll and return to Original Medicare If no new plan is chosen during the final month of coverage, the SEP extends for 90 days from the date of disenrollment.	Coverage with the new plan begins on the first of the month after the new plan receives the completed application, or up to three months later, depending on the individual's request. Note: In some cases, retroactive disenrollment or enrollment may be granted by CMS.
A federal employee makes an error in processing the individual's enrollment or disenrollment in a Medicare Part D plan. Example: • A Social Security representative mistakenly removes a beneficiary from their Part D plan.	The individual has one SEP, which begins the month CMS approves the correction and lasts for two additional months.	Depends on the situation. CMS may allow retroactive coverage or reinstatement.
CMS sanctions a Medicare Advantage or Part D plan, and the individual disenrolls in response to that sanction.	The SEP's start date and duration vary depending on the nature and timing of the CMS sanction.	Depends on the situation. Start date may align with disenrollment or CMS determination.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
Example: • A plan is penalized for non-compliance with CMS requirements, and the member chooses to leave.		
CMS determines that the individual's previous drug coverage was not creditable, or that the plan failed to properly notify them of loss of creditable coverage. Example: • A former employer plan did not meet Medicare's standards and failed to send proper notice.	The SEP begins the month CMS approves the request and lasts for two additional months. CMS may also waive any late enrollment penalty in this situation.	Depends on the situation. Retroactive enrollment may be possible if CMS permits.

14. The individual's plan no longer offers coverage.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual's Medicare Advantage Plan or Part D plan does not renew its contract for the upcoming year. Plans must notify members by October 1 and must continue coverage through December 31 of the current year. Examples include: • A stand-alone Part D plan leaves the market in 2026 and notifies enrollees in fall 2025. • A Medicare Advantage Plan decides not to renew its contract with CMS for the upcoming year.	The SEP to switch plans begins December 8 of the current year and ends February 28 of the following year. This SEP is in addition to Fall Open Enrollment (October 15 – December 7).	• Enrollments from Oct 15 – Dec 31 take effect Jan 1 • Enrollments in January take effect Feb 1 • Enrollments in February take effect Mar 1
A plan closes or modifies its contract mid-year, requiring members to disenroll. CMS requires the plan to send notification at least 60 days in advance. Example: • A plan stops offering service in a rural region mid-year.	SEP begins two months before the termination or change and ends one month after the event occurs.	The individual may choose coverage to begin: • The month after they receive notice, or • Up to two months after their old plan ends
CMS terminates a plan's contract for misconduct or compliance issues. Plans must give at least 30 days' notice before the termination date. Example: • CMS ends a contract due to financial or quality-of-care violations.	SEP begins one month before the contract termination date and lasts for two months afterward.	The individual may choose to begin coverage up to three months after the month their old plan ends.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
CMS immediately terminates a plan's contract without advance notice (e.g., in cases of fraud or critical safety concerns).	CMS will issue a notification outlining the SEP's timing and instructions. Termination may occur mid-month.	Depends on the situation and instructions provided by CMS.

15. The individual disenrolls from a Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual disenrolls from a Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period (MA OEP), which runs from January 1 to March 31 each year. Examples include: • A person with a Medicare Advantage HMO switches to Original Medicare + Part D. • A beneficiary decides to move from one Medicare Advantage Plan to another.	SEP is valid once per year during the MA OEP. The individual may: • Disenroll from a Medicare Advantage Plan and return to Original Medicare with or without joining a stand-alone Part D drug plan, or • Switch to another Medicare Advantage Plan	Coverage under the new plan begins the first day of the month after the enrollment request is submitted. Example: If a person submits an enrollment request in February, new coverage begins March 1.

16. The individual qualifies for a new Part D Initial Enrollment Period upon turning 65.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual qualifies for a new Initial Enrollment Period (IEP) for Medicare Part D upon turning 65, after having previously qualified for Medicare due to disability. Examples include: • A 62-year-old on Medicare due to disability turns 65 and becomes eligible for a new IEP. • A beneficiary paying a late enrollment penalty for Part D coverage can use this IEP to enroll in a new plan and have the penalty removed.	The SEP aligns with the Part D Initial Enrollment Period (IEP), which usually lasts seven months: three months before turning 65, the birthday month, and three months after. During this time, individuals also have an SEP to join a Medicare Advantage Plan. They can use these SEPs to: • Leave a Medicare Advantage Plan and return to Original Medicare with a stand-alone Part D plan • Enroll in a Medicare Advantage Plan that includes drug coverage • Enroll in a Medicare Advantage Plan without drug coverage	If not already enrolled in Part D, coverage typically begins the first day of the month after submitting an enrollment request. Example: • If the request is submitted in May, coverage begins June 1.

17. The individual wants to enroll in a five-star Medicare Advantage or Part D plan.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual wishes to enroll in a Medicare Advantage or Part D plan that has an overall 5-star Plan Performance Rating and they meet all other eligibility requirements (such as living in the plan's service area). Examples include: • A person currently enrolled in a 3-star plan wants to switch to a newly available 5-star plan in their area. • A beneficiary in Original Medicare decides to join a 5-star Medicare Advantage Plan.	The SEP begins December 8 of the year before the plan is rated five stars and ends November 30of the year the rating applies. • The SEP may only be used once per calendar year.	• Enrollments between Dec 8 – Dec 31 are effective Jan 1 • Enrollments between Jan 1 – Nov 30 take effect the first day of the following month

18. The individual is enrolled in a consistently low-performing Medicare Advantage or Part D plan

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual is enrolled in a consistently low-performing plan, meaning the plan has received an overall Medicare star rating of less than three stars for three consecutive years. Examples include: • A Medicare Advantage Plan with poor customer service and delayed drug access continues to receive low scores for three years. • A stand-alone Part D plan with consistent coverage issues remains rated below 3 stars.	SEP is available during: • The remainder of the year the CMS notice is received, and • The entire following year To use this SEP, the individual must call 1-800-MEDICARE. This SEP is separate from the five-star plan SEP.	Coverage begins the first day of the month after submitting the completed enrollment request. Example: • Application submitted in August → Coverage begins September 1.

19. The individual's Medicare Advantage Plan significantly reduces its network of providers.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
A Medicare Advantage Plan terminates contracts with a significant number of healthcare providers during the calendar year, and the Centers for Medicare & Medicaid Services (CMS) determines that the terminations are substantial. Examples include: • A plan drops 40% of its in-network primary care providers or specialists. • A hospital system withdraws from the plan's network mid-year.	The SEP begins in the month the individual receives written notice from the plan (CMS requires at least 30 days' advance notice) and lasts for two additional months. During this time, the individual may: • Enroll in another Medicare Advantage Plan, with or without drug coverage, or • Switch to Original Medicare with or without a stand-alone Part D plan	Coverage with the new plan begins the month following the month the enrollment request is submitted. Example: • If the application is submitted in June, coverage begins July 1. Note: This SEP does not guarantee the right to purchase a Medigap policy.

20. The individual experiences an exceptional circumstance.

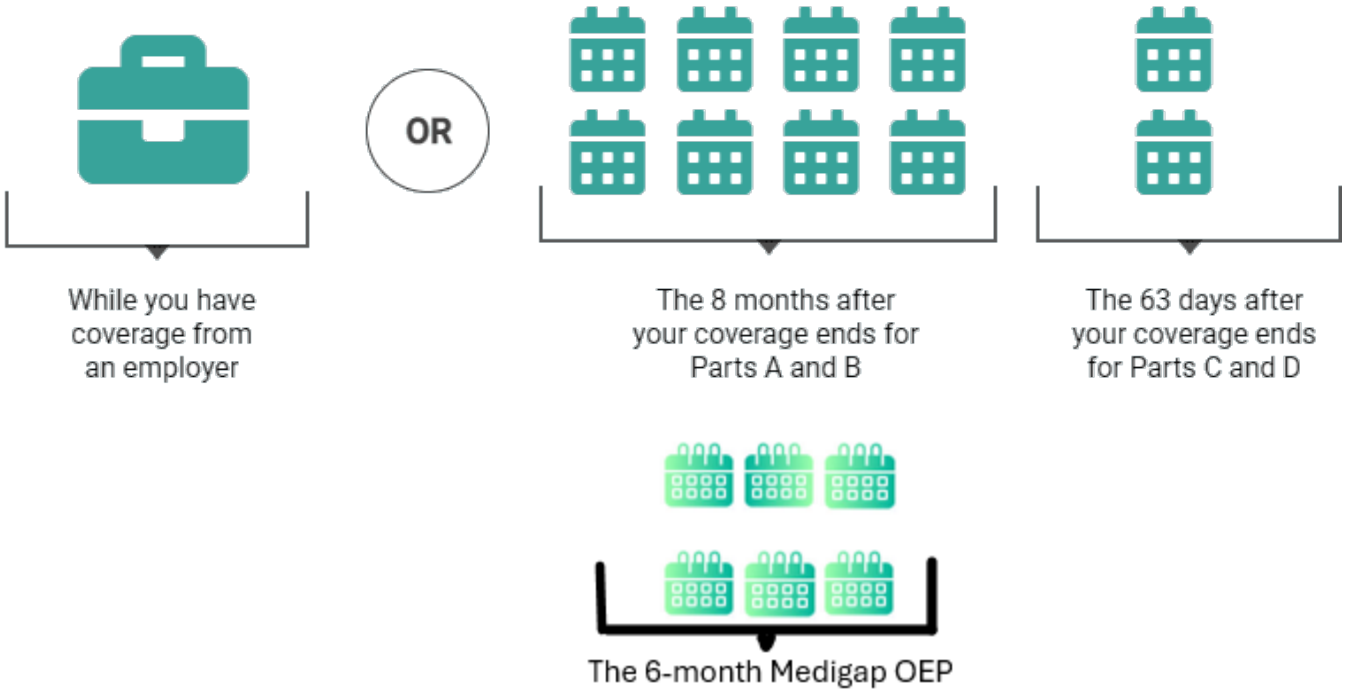
An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual experiences an exceptional circumstance not covered by other SEP categories and requests a special enrollment period from CMS. Examples include: • Being affected by a natural disaster • Serious administrative errors • Domestic abuse impacting health coverage decisions • Other unique hardships not listed in standard SEPs	SEP duration varies depending on the nature of the exceptional circumstance and CMS approval. CMS will specify the start and end dates of the SEP in the approval letter.	Coverage start date depends on the specific situation and guidance from CMS. In some cases, retroactive coverage may be granted.

21. The individual enrolls in Part B or premium Part A using an exceptional circumstances SEP.

An individual has a Special Enrollment Period (SEP) if…	The SEP lasts…	The new coverage begins…
An individual enrolls in Part B or Premium Part A through a CMS-approved exceptional circumstances SEP. Examples include: • Enrollment delayed due to a natural disaster or emergency • Misinformation from an employer about Medicare enrollment • Release from incarceration • Medicaid coverage ending • Other exceptional circumstances verified by CMS	The SEP to join a Medicare Advantage Plan begins the day the individual submits their application for Premium Part A and/or Part B. The SEP lasts for two months after they are enrolled in both Part A and Part B.	Coverage under the Medicare Advantage Plan begins the first day of the month after the plan receives the enrollment request. Example: • Enrollment request submitted in July → Coverage starts August 1.

Appendix C: timelines

Case-related Special Enrollment Periods for Parts A, B, C and D as well as Medigap OEP



Resources

Centers for Medicare Advocacy

Eligibility & Enrollment

https://medicareadvocacy.org/eligibility-enrollment/

Centers for Medicare & Medicaid Services

Original Medicare (Part A and B) Eligibility and Enrollment

https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b#:~:text=A%20person%20may%20be%20eligible%20if%20they,ends%20six%20months%20after%20the%20Medicaid%20termination.

Medicare Coverage Determination Process

https://www.cms.gov/medicare/coverage/determination-process#:~:text=Medicare%20coverage%20is%20limited%20to,Security%20Act%20(the%20Act).

Medicare Rights Center

Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans

https://www.medicareinteractive.org/resources/special-enrollment-periods-for-medicare-advantage-and-part-d

Notices that Medicare Advantage and Part D plans must send if they make changes during the year

https://www.medicareinteractive.org/understanding-medicare/health-coverage-options/medicare-advantage-plan-overview/notices-that-medicare-advantage-and-part-d-plans-must-send-if-they-make-changes-during-the-year

Medicare.gov

What Original Medicare covers

https://www.medicare.gov/providers-services/original-medicare