

SHIBA/SMP Gearing up for Open Enrollment I workbook

September 2025

Statewide Health Insurance Benefits Advisors
(SHIBA)

Senior Medicare patrol (SMP)

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Message from 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

SHIBA Curriculum & Training Coordinator

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Medicare Annual Open Enrollment Period (OEP) October 15-December 7

Who Is It For?	What Beneficiaries Can Do	When Does Coverage Start?
Anyone who is enrolled in Medicare Parts A and/or B, including those who may already be enrolled in a Medicare Advantage or Part D plan	<ul style="list-style-type: none">• Change from original Medicare to a private Medicare Advantage plan• Change from Medicare Advantage to Original Medicare• Join, drop, or switch Part D drug plans• Switch Medicare Advantage plans	Jan. 1

Employer-sponsored plans OEP: special case

Timing: Though most employers schedule their open enrollment period once a year, often in the fall, with November 1st being a common start date, enrollment dates can vary significantly between employers.

- E.g. HCA PEBB Medicare retirees' Open Enrollment Period: October 28th to November 25th

Purpose: This is the time when employees, including retirees, can enroll in or make changes to their employer-sponsored health insurance plans.

Key information

September 2025	Beneficiary receives the Annual Notice of Change (ANOC) from their Medicare Advantage or Part D plan
October 16 to December 7, 2025	Beneficiaries need to compare their current Medicare health or drug coverage with options for 2026. They might be able to save money, get better care, or extra benefits. Medicare.gov/plan-compare
January 1, 2026	New coverage begins if changes are made. If a beneficiary kept their existing coverage and their plan's costs or benefits changed, those changes also start on this date.

Annual notices: ANOC & EOC

Annual Notice of Change (ANOC)

An Annual Notice of Coverage (ANOC) is sent out by your Medicare Advantage Plan or Part D plan and provides information about changes to coverage in the upcoming year.

It's usually sent out around September, since it can help beneficiaries decide if they want to make changes to their coverage during Medicare's Fall Open Enrollment period, which runs from October 15th to December 7th.

Three kinds of changes to look for in an ANOC:

- Changes to a plan's costs like premiums, deductibles, and copays.
- Changes to a plan's network that might affect coverage for a beneficiary's current providers and pharmacies
- Changes to a plan's formulary that might affect coverage of a beneficiary's current drugs or their prices.

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.

Step 1: Remind the Beneficiary to Check Their Mailbox¹

Counselors should encourage beneficiaries to pay close attention to any official mail they receive during the fall. While marketing materials from insurance companies can be overwhelming, it's important not to miss critical notices from Medicare, Social Security, or their current plan.

Here are some examples of important mail they may receive:

- **Plan termination notices:** If a plan is ending its contract with Medicare or will no longer be available in their area, beneficiaries will get a letter—usually in October—with a reminder in November. They'll need to choose a new plan for the next year.
- **Extra Help notices:** Beneficiaries who receive Extra Help for prescription drug costs may get updates about their eligibility, pharmacy copay changes, or instructions for choosing a new plan if theirs is ending.
- **Other plan notices:** Even if beneficiaries already reviewed their Annual Notice of Change (ANOC), they may receive additional updates or reminders from their plan. It's important to open and read all mail related to their Medicare coverage.

Counselors should remind beneficiaries that missing or ignoring these notices can lead to gaps in coverage or unexpected costs—so it's worth sorting through the stack of fall mail carefully².

Step 2: Help the Beneficiary Review Their Annual Notice of Change (ANOC)

Counselors should encourage beneficiaries to review their *Annual Notice of Change (ANOC)* every year. Medicare plans can change each year, so it's important to make sure their current plan will still meet their needs in the coming year.

¹ Guide to consumer mailings from CMS, SS, and plans in 2024/2025 <https://www.cms.gov/medicare/prescription-drug-coverage/limitedincomeandresources/downloads/consumer-mailings.pdf>

² See Appendix F: Medicare Plan Documents & Notices – Summary Table

When going over the ANOC with a beneficiary, help them focus on these key areas:

- **Monthly premium** – Will they pay more, less, or the same?
- **Deductible** – Is the amount they pay before coverage starts going up or down?
- **Maximum out-of-pocket costs** – Is there a change to the most they might have to pay in a year?
- **Copayments or coinsurance** – Will their share of the cost for services or drugs be different?
- **Provider network** – Are there changes to doctors, hospitals, or pharmacies in their plan?

Medicare Advantage plans are required by the Centers for Medicare & Medicaid Services (CMS) to keep their online provider directories updated.

- **Drug coverage** – Have any medications been added, removed, or moved to a different pricing tier?

Remind beneficiaries to compare costs at their preferred pharmacy or for mail-order prescriptions when reviewing and comparing plans. These options can vary in price depending on the plan.

- **Other services** – Are there any new benefits or services being dropped?

Remind beneficiaries that the ANOC is a helpful tool to see whether their plan will still fit their health needs and budget. If they haven't received it by September 30, they should call their plan and ask for a copy.

Step 3: Help the Beneficiary Assess Their Coverage Needs

Counselors should guide beneficiaries in thinking about whether their current Medicare plan still meets their needs—or if it's time to consider switching during Open Enrollment. After reviewing the Annual Notice of Change and reflecting on

their healthcare use over the past year, help them explore whether a different Medicare Advantage or Part D plan might be a better fit.

Key questions to help beneficiaries consider:

- **Have their healthcare needs changed?**

Did they start seeing a new specialist or need different care this year? Does their current plan still support those needs?

- **Do Medicare Advantage plans meet their needs?**

Help them check if their preferred doctors, specialists, and services are still covered. Remind them to look closely at any limits on extra benefits like dental, vision, or hearing.

- **Are their prescription drugs still covered?**

Make sure any plan they're considering includes the medications they expect to need in 2026. Ask about drug restrictions, like quantity limits or prior approval.

- **What are the out-of-pocket costs?**

Help them understand what they'll pay when they visit a doctor, go to the hospital, or fill a prescription. Be sure they know that most plans include an annual out-of-pocket maximum—but drug costs usually aren't counted in that limit.

By answering these questions, beneficiaries can make informed choices about whether to keep their current plan or switch to one that better meets their needs and budget.

Beneficiaries who reviewed their ANOC letter, found no concerning changes, and decided—after carefully evaluating their Medicare plan—that they wish to keep it don't need to take any action. Their current Medicare coverage will automatically renew for the following year.

Notices for changes during the year³

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
- 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.

³ <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>

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.

Supplemental benefits in 2026

Midyear notice of unused supplemental benefits

- Plans will have to notify enrollees about unused supplemental benefits mid-year. CMS will require this change starting in **January 2026**.
 - One purpose of the Mid-Year Notice is to address concerns that some MA plans may be using supplemental benefits primarily as marketing tools to steer enrollment.

Evidentiary basis for Supplemental Benefits for Chronically Ill enrollees (SSBCI)

- CMS will require plans to demonstrate that SSBCI have a reasonable expectation of improving the health or overall function of the enrollee with a chronic condition.

Marketing and communications

- CMS will require plans to include an SSBCI marketing and communications disclaimer saying that a supplemental benefit is only available if the individual:
 - Has a particular chronic condition
 - Meets Medicare's definition of a "chronically ill enrollee" and
 - Is deemed eligible for the benefit by the plan

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.

Open Enrollment

Activity 1: Medicare Open Enrollment Experience

Objective: To help you reflect on your past experiences with Medicare Open Enrollment and identify strategies to address common challenges.

Instructions:

Reflect on the time when you assisted a beneficiary during the Medicare Open Enrollment period.

1. What are the most common questions beneficiaries asked?

2. What challenges did you face? How did you overcome them?

3. What worked well? Why do you think it worked so well?

-
-
4. Write down two or three key strategies that you found most effective in overcoming the challenges you faced.
-
-

Gearing up for OEP: New in 2026

New Medicare eligibility restrictions⁴

Previously, many lawfully present immigrants could qualify for Medicare if they met work history or residency requirements—just like U.S. citizens.

Now, due to changes in the H.R. 1 Budget Reconciliation Bill, only the following groups can newly enroll in Medicare:

- U.S. citizens
- Lawful permanent residents (green card holders)
- Cuban and Haitian Entrants
- Citizens of certain Pacific Island nations with special U.S. agreements (known as Compact of Free Association (COFA) migrants⁵)

Who is now excluded from Medicare eligibility?

Even if they have worked and paid taxes, the following lawfully present immigrants can no longer enroll in Medicare:

- Refugees and people granted asylum
- Individuals with Temporary Protected Status (TPS)
- Survivors of human trafficking
- Survivors of domestic violence
- Individuals granted humanitarian parole

By July 2026 the Social Security Administration must identify current Medicare beneficiaries who do not meet the above immigration criteria and notify them that their coverage will end in January 2027.

⁴ <https://medicareadvocacy.org/impact-of-the-big-bill-on-medicare/?emci=a0af8eff-a368-f011-8dc9-6045bda9d96b&emdi=08c389b9-c268-f011-8dc9-6045bda9d96b&ceid=11964873>

⁵ COFA migrants from the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau, collectively known as the Freely Associated States, are Qualified Non-Citizens.

Medicaid in 2026⁶

For today, there are no changes in Medicaid that affect Medicare beneficiaries in 2026.

- No changes to income eligibility for most people
- Many cuts are not in effect for months or years
 - Eligible individuals should get and remain enrolled
- All individuals have due process protections
 - No changes to requirement for written notice prior to termination and right to appeal adverse decisions

We will provide updates on any changes if, and as soon as, we learn more.

Original Medicare in 2026: prior authorization

For your information only. Volunteer counselors are not expected to provide counseling on this change.

Original Medicare has historically required little in the way of pre-authorization for beneficiaries seeking services. However, starting January 1, 2026, Washington State will begin requiring prior authorizations for certain services under Original Medicare. This is part of a new pilot called the WISeR Model (Wasteful and Inappropriate Service Reduction) ⁷, designed to reduce unnecessary care and

⁶Justice in Aging presentation: <https://justiceinaging.org/wp-content/uploads/2025/08/8.13.25-H.R.-1-Medicaid-and-Medicare-Overview.pdf>

⁷ CMS press release: <https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare#:~:text=CMS%20launches%20New%20Model%20to%20Target%20Wasteful%2C%20Inappropriate%20Services%20in%20Original%20Medicare.&text=The%20WISeR%20Model%20will%20test%20a%20new,fraud%2C%20waste%2C%20and%20abuse%2C%20or%20inappropriate%20use.https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#print>
Wasteful and Inappropriate Service Reduction (WISeR) Model Office Hour:
<https://www.youtube.com/watch?v=CATxta1fFu4>

protect Medicare funds. These services were selected based on evidence of fraud, waste, and abuse, as well as alignment with existing Medicare Advantage prior authorization practices. The services include items like electrical nerve stimulators, sacral nerve stimulation for urinary incontinence, and skin and tissue substitutes for lower extremity wounds.⁸

Moreover, these services were selected because they often offer minimal benefit to patients and can sometimes cause physical harm, stress, or unnecessary costs.

Centers for Medicare & Medicaid Services (CMS) have said they will:

- Exclude any services that would pose serious risk if delayed
- Monitor the pilot closely for quality and patient impact
- Require timely and accurate decisions from providers
- Allow appeals if services are denied

Counselor Corner: OM prior authorization

This change is not expected to have a significant impact on most Medicare beneficiaries.

SHIBA staff will handle any concerns that come up⁹, and volunteer counselors are not expected to explain or assist with prior authorization issues.

Part D in 2026

Creditable Coverage¹⁰

If someone with Medicare doesn't enroll in Part D and goes 63 days or more without creditable drug coverage, they may have to pay a late enrollment penalty.

⁸ For the complete list of services, please see: [https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#:~:text=Beginning%20January%201%2C%202026%2C%20the%20prior%20authorization,Nerve%20Stimulation%20for%20Urinary%20Incontinence%20\(NCD%20230.18\)&text=Deep%20Brain%20Stimulation%20for%20Essential%20Tremor%20and,\(NCD%20160.24\)%20Vagus%20Nerve%20Stimulation%20\(NCD%20160.18\)](https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#:~:text=Beginning%20January%201%2C%202026%2C%20the%20prior%20authorization,Nerve%20Stimulation%20for%20Urinary%20Incontinence%20(NCD%20230.18)&text=Deep%20Brain%20Stimulation%20for%20Essential%20Tremor%20and,(NCD%20160.24)%20Vagus%20Nerve%20Stimulation%20(NCD%20160.18))

⁹ <https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#print>

¹⁰ <https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions>

Drug coverage is considered **creditable** if it is as good or better than Medicare's drug coverage.

Group health plans, like Employer Group Waiver Plan (EGWP), that don't apply for the retiree drug subsidy (RDS), can determine if their coverage is creditable by comparing it to Medicare's standard plan using a method provided by CMS.

CMS has updated the method for deciding if coverage is creditable, requiring plans to pay at least 72% of participants' drug costs.

CMS recognizes that the higher actuarial value could cause some drug plans to lose creditable coverage status. To ease the transition, employers may use either the current or updated simplified standard in 2026.

For 2026 only, group health plans can use either:

- The old method (coverage must pay at least 60% of drug costs), or
- The new method (coverage must pay at least 72% of drug costs).

Counselor Corner: Employer Drug Coverage and Medicare Part D

When speaking with beneficiaries who are still working or covered under an employer plan, it's important to:

- **Ask if they've received a Notice of Creditable Coverage.**
Employers who offer prescription drug coverage are required to send this notice each year to employees eligible for Medicare Part D. It tells them whether their current drug plan is considered creditable—meaning it is as good as or better than Medicare's drug coverage.
- **Explain why this notice matters.**
If a Medicare-eligible individual goes 63 or more days without creditable drug coverage, they may face a lifetime Part D late enrollment penalty when they eventually sign up, unless they qualify for Extra Help.
- **Clarify that not all employer coverage is creditable.**
Even though employers aren't required to offer drug coverage, if they do—and it's not creditable—employees may still need to enroll in Medicare Part D on time to avoid penalties.

- **Encourage beneficiaries to verify their coverage status each year.**
Let them know they should not assume their drug coverage is creditable just because it comes from an employer. They must read the annual notice carefully and make timely decisions about enrolling in Part D if needed.

2026 Part D structure (phases)¹¹

In CY 2026, the structure of Part D benefit includes the following three phases:

1. Annual deductible.
 - The enrollee pays 100 percent of their prescription drug costs until the deductible is met. While maximum deductible in 2025 is \$590 (expected to increase in 2026 to \$615), some plans may have a lower deductible, including some with a \$0 deductible. Deductibles can also vary depending on whether the individual has Extra Help.
2. Initial coverage:
 - The enrollee pays 25 percent coinsurance for covered Part D drugs.
 - This phase ends when the enrollee has reached the annual OOP spending threshold of \$2,100 (in 2026).
3. Catastrophic coverage.
 - The enrollee pays no cost sharing for Part D drugs.

Increased Part D Out-of-Pocket Maximum & Maximum deductible

- The annual out-of-pocket spending limit for prescription drugs will increase to \$2,100, a \$100 increase from the 2025 limit of \$2,000.
- The annual maximum Part D plan deductible in 2026 will increase to \$615, a \$25 increase from 2025 max of \$590

¹¹ <https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf> P.34

Medicare Prescription Payment Plan¹² in 2026: Automatic re-enrollments

The Medicare Prescription Payment Plan offers Medicare Part D enrollees the option to pay out-of-pocket prescription drug costs in the form of capped monthly payments instead of all at once at the pharmacy. All Medicare prescription drug plans are required to offer this benefit to enrollees.

Beneficiaries participating in the [Medicare Prescription Payment Plan](#) in 2025, starting in 2026 they will be automatically re-enrolled each year unless they opt out.

PPP: Who benefits the most?

While this program is available on opt-in basis to anyone with Medicare Part D, enrollees with high cost sharing earlier in the plan year are more likely to benefit from the program.

For Medicare enrollees with Part D who are eligible for the Low-Income Subsidy (LIS) (also known as Extra Help), enrollment in Extra Help is more advantageous than the Medicare Prescription Payment Plan.

Counselor corner: PPP

Tip 1: Encourage individuals to check their eligibility for Low-Income Subsidy (LIS) programs before they consider participating in the Medicare Prescription Payment Plan.

Tip 2: The threshold for identification of Part D enrollees who are likely to benefit from PPP is a \$600 pharmacy Point of Sale (POS) threshold based on a single prescription. This approach identifies Part D enrollees with a very high likelihood of benefiting from the Medicare Prescription Payment Plan program, while reducing the risk of identifying Part D enrollees for whom the program may not be as helpful.¹³

¹² **Medicare Prescription Payment Plan**

<https://www.cms.gov/medicare/health-drug-plans/medicare-prescription-payment-plan#:~:text=The%20Medicare%20Prescription%20Payment%20Plan,offer%20this%20benefit%20to%20enrollees.>

¹³ <https://www.cms.gov/files/document/fact-sheet-medicare-prescription-payment-plan-final-part-one-guidance.pdf>

Part D vaccines & insulin

Adult vaccines

No deductible or cost sharing be applied with respect to adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Insulin

Beginning January 1, 2023, Medicare Part D plans are no longer allowed to apply a deductible to covered insulin products. This means enrollees do not have to pay out of pocket before their plan begins covering insulin.

For the years 2023, 2024, and 2025, the cost for a one-month supply of each covered insulin product is capped at \$35.

Changes to Insulin Costs Under Medicare¹⁴

Starting in 2026 and for each year after, before a beneficiary reaches their annual out-of-pocket spending limit, the cost for each one-month supply of covered insulin will be the lowest of the following:

- \$35,
- 25% of the drug's Medicare-set maximum fair price, or
- 25% of the negotiated price between the drug plan and the pharmacy.

These rules apply to both stand-alone Medicare drug plans (Part D) and Medicare Advantage plans that include drug coverage.

Plan Finder 2026: vaccines & insulin

Plan Finder will reflect the no cost-sharing for adult vaccines recommended by ACIP and the cap on insulin costs.

¹⁴ <https://www.federalregister.gov/documents/2025/04/15/2025-06008/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare>

Activity: Part D Prescription Drug Coverage

Activity: Document list of options, challenges, and success strategies that you can reference during future counseling sessions.

- 1. Write down the different options you typically discuss with beneficiaries regarding prescription drug coverage, including both Medicare and non-Medicare options and resources you use.

Options	Resources

- 2. Think back to a challenging question you’ve been asked about Medicare Part D. Share the question with your peers and ask how they would handle it. You may also share your own response. Record the answers you receive.

Question(s):

What made it(them) challenging?

Possible answers:

Medicare.gov¹⁵

Counselor corner: Medicare.gov account

Encouraging Beneficiaries to Create a Medicare.gov Account (or Offering to Help)

Here's how to explain the benefits and support them through the process:

1. Explain what Medicare.gov is and why it's a valuable service

Medicare.gov is Medicare's free, secure online service that helps beneficiaries manage their personal information and access services related to **Original Medicare**. With a Medicare.gov account, beneficiaries can:

- Check their coverage and enrollment status
- View Medicare claims in near real time
- Track out-of-pocket costs more effectively than waiting for the quarterly Medicare Summary Notices (MSNs)
- Keep their information private and accessible only to them

2. Connect the account to Medicare Plan Finder (MPF)

Let them know that the MPF—used to compare drug and health plans—can pull personalized data when they're logged in with their Medicare.gov credentials. This makes comparing plans faster, more accurate, and easier to revisit later.

♦ *Note:* A general search on MPF can still be done without logging in, but the personalized search is more useful for beneficiaries with complex medication lists or specific needs.

3. Offer to help them create an account

Once the benefits are clear, offer support in creating an account:

- Walk them through the process step-by-step, either in person or over the phone

¹⁵ <https://www.medicare.gov/care-compare/>

- Let them control the process while you provide guidance
- Be sure they write down their username and password or store them securely

If the beneficiary is not comfortable setting it up themselves, and they consent, you may offer to set up the account on their behalf using their information. Make sure they understand how to log in and update their password later if needed.

4. Encourage follow-up

If the client isn't ready to create an account during your session, consider:


- Sending them instructions to do it later (See Appendix B)
- Offering to revisit it at their next appointment, especially during Open Enrollment
- Reminding them that this one-time setup makes all future comparisons and claims tracking easier


Original Medicare: Find & compare providers


You and your clients can use this tool <https://www.medicare.gov/care-compare/> to find and compare different types of Medicare providers—such as physicians, hospitals, nursing homes, and more. Encourage beneficiaries to explore the map and filters to help identify providers that meet their needs.


Find & compare providers near you.





 Not sure what type of provider you need?
[Learn more about the types of providers.](#)


 Welcome


 Doctors & clinicians


 **Hospitals**


 Nursing homes including rehab services


 Home health services

 Hospice care

 Inpatient rehabilitation facilities

 Long-term care hospitals

 Dialysis facilities

 Medical equipment & suppliers


Find hospitals near me

Find and compare information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers and over 50 military hospitals, across the country.

MY LOCATION
Enter street, ZIP code, city, or state.

NAME OR TYPE (optional)
Enter the hospital name or a type of hospital.

Or want to learn more about ambulatory surgical centers (ASC)? [Visit the ASC data on Data.cms.gov](#)

[Find out what's new](#) 

Medicare Plan Finder (MPF) tool: Medicare Advantage key updates

Enhanced Provider Directories: Medicare Advantage (MA) plans will be required to provide more detailed and accessible provider directory information through the Plan Finder tool. This aims to make it easier for beneficiaries to find in-network providers when comparing plans.

Integration of Part D Information: The tool will provide clarity on changes to Part D prescription drug coverage, including the new \$2,100 out-of-pocket cap and the Medicare Prescription Payment Plan features like automatic renewal.

Information on Insulin and Vaccine Coverage: Plan Finder will reflect no cost-sharing for adult vaccines recommended by ACIP and the cap on insulin costs.

Other helpful MA plan features

MPF filters for:

- MA plans carrier choices (Exhibit 1)
- PPO vs HMO (Exhibit 1)
- MA plans supplemental benefits (Exhibit 1)
- D-SNPs (Exhibit 2)

Those who select the Medicaid checkbox on the 'Help with your costs' page will see on the Plan Results page:

- The D-SNP filter pre-selected
- An informational alert with content about Special Needs Plans

Exhibit 1

Research findings

Plan quantities next to filter options had no negative impact and appeared to help set user expectations.

Medicare.gov

Back to drugs & other products

MY LOCATION: Baltimore, MD [Change location](#)

PLAN TYPE: Select a Plan Type

Filter by:

- Plan Benefits
- Insurance Carrier
- Drug Coverage
- Star Ratings
- [View all filters](#)

Showing 10 of 26 Medicare Advantage Plans

Sort Plans By: Lowest drug + premium cost

Erickson Advantage Liberty (HMO-POS)
 UnitedHealthcare | Plan ID: H5652-008-0
 Star ratings: (5) This plan has Medicare's highest rating (5 stars)

1

Insurance Carrier

- ☐ Aetna Medicare (2)
- ☐ Alterwood Advantage (2)
- ☐ CareFirst BlueCross BlueShield M Advantage (1)
- ☐ Cigna Healthcare (2)
- ☐ Communicare Advantage (2)
- ☐ Humana (4)
- ☐ Johns Hopkins Advantage MD (2)
- ☐ Kaiser Permanente (3)
- ☐ UnitedHealthcare (2)

[Clear](#) [Apply](#)

Drug Coverage

- ☐ Includes drug coverage (28)
- ☐ Doesn't include drug coverage (6)

[Clear](#) [Apply](#)

FILTER DROPDOWNS

2

Filter Plans

PLAN BENEFITS

- ☐ Vision coverage (20)
- ☐ Dental coverage (18)
- ☐ Hearing coverage (20)
- ☐ Transportation (12)
- ☐ Fitness benefits (9)

PLAN TYPE

☒ Medicare Advantage

Types of Medicare health plans
[Learn about plan types](#)

- ☐ HMO (Health Maintenance Organization) (15)
- ☐ PPO (Preferred Provider Organization) (5)
- ☐ Prescription Drug Plans

INSURANCE CARRIER

Select insurance carrier

[Apply Filters](#) [Clear all filters](#)

Exhibit 2

An official website of the United States government [Here's how you know](#) ▼

Medicare.gov Basics ▼ Health & Drug Plans ▼ Providers & Services ▼ Chat Logout

There may be separate drug plans available with lower drug costs. [Tell me more.](#) [View 21 available drug plans](#)

< [Back to drugs & pharmacies](#) [Print](#)

MY LOCATION: Baltimore, MD [Change location](#) PLAN TYPE: Select a Plan Type ▼

1 Plan Categories ▼ Insurance Company ▼ Drug Coverage ▼ **Special Plans ▼** Plan Benefits ▼ [View all filters](#)

Dual Eligible Medicaid and Medicare Plans (D-SNP) X


Showing 10 of 11 Medicare Advantage Plans SORT PLANS BY: Lowest drug + premium cost ▼



2 **D-SNP (Dual Eligible Special Needs Plans)**
Plans with "D-SNP" in the title are special plans that help you coordinate your Medicare and Medicaid benefits. Some D-SNPs may also provide Medicaid services in addition to Medicare services. [What are the eligibility criteria for Special Needs Plans?](#)


Alterwood Advantage Dual Value (HMO D-SNP)
Alterwood Advantage | Plan ID: H9306-007-0
Star rating: ★★☆☆☆







MONTHLY PREMIUM	PLAN BENEFITS
\$41.30 Includes: Health & drug coverage Doesn't include: \$174.70 Standard Part B premium This plan is designed for beneficiaries with Medicare and Medicaid. SNP Type: Dual Eligible	✓ Vision ✓ Dental ✓ Hearing ✓ Transportation ✓ Fitness benefits ✗ Worldwide emergency ✓ Telehealth See more benefits ▼
TOTAL DRUG & PREMIUM COST (for the rest of 2024) \$371.70 <small>Only includes premiums for the months left in this year when you don't enter any drugs</small>	COPAYS/COINSURANCE

OIC website: Help beneficiaries navigate it & find Medicare counseling events in their area¹⁶



Online Services  Language 



How can we help you... 

Insurance Resources  Complaints, Appeals & Fraud  Producers & Adjusters  Insurers & Regulated Entities  Laws & Rules  About Us 


Home > Insurance Resources > Medicare > Get free Medicare help from SHIBA > Find Medicare counseling and events in your area

Find Medicare counseling and events in your area

Use this calendar to find Medicare counseling sessions and events. You can filter by date, county, sponsor or type of event.

September 2025  

S	M	T	W	T	F	S
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	1	2	3	4
5	6	7	8	9	10	11

Keyword Search 


Location Type

☒ In-Person


☒ Online

Select: [All](#) [None](#)

County

Select a County 

Local sponsor

Select a Sponsor 

Type of Event

☒ Fraud presentation

☒ Health fair

☒ Medicare class

☒ Medicare Open Enrollment event



☒ One-on-one counseling session



☒ Walk-in clinic

☒ Welcome to Medicare presentation

☒ Other

Select: [All](#) [None](#)

Table List Month Title  

 Print  Subscribe

Monday, September 1, 2025

When	Event	Location
September 1, 9am – 12pm	Edmonds Waterfront Center In-Person Appointments	220 Railroad Ave, Edmonds, WA 98020
September 1, 9am – 12pm	SHIBA Medicare 1:1 In-person Counseling Session (Puyallup)	Puyallup Activity Center 210 West Pioneer Puyallup, WA 98371
September 1, 10am – 1pm	Anacortes Activity Center In-person Appointments	1701 22nd St Anacortes, WA 98221
September 1, 10am – 3pm	Get Medicare help by phone from a SHIBA volunteer (Thurston, Mason counties)	
September 1, 1 – 4pm	Edmonds Waterfront Center In-Person Appointments	220 Railroad Ave, Edmonds, WA 98020
September 1, 1 – 4pm	SHIBA Medicare 1:1 counseling (San Juan County)	

Tuesday, September 2, 2025

When	Event	Location
September 2, 9am – 12pm	Edmonds Waterfront Center In-Person Appointments	220 Railroad Ave, Edmonds, WA 98020
September 2, 9am – 12pm	SHIBA Medicare 1:1 In-person Counseling Session (Tacoma)	Sound Outreach 1116 S 11th St Tacoma, WA 98405
September 2, 10am – 12pm	1:1 confidential and free help navigating Medicare	Shipley Center 821 E Hammond St Sequim, WA 98368
September 2, 10am – 3pm	Get Medicare help by phone from a SHIBA volunteer (Thurston, Mason counties)	
September 2, 1 – 3pm	1:1 confidential and free help navigating Medicare	Port Townsend Senior Center 620 Tyler St Port Townsend, WA 98368
September 2, 1 – 4pm	SHIBA Medicare 1:1 in person counseling (Orcas Island)	
September 2, 1 – 4pm	SHIBA Medicare 1:1 In-person Counseling Session (Isakau)	Mustard Seed Project

¹⁶ <https://www.insurance.wa.gov/insurance-resources/medicare/get-free-medicare-help-shiba/find-medicare-counseling-and-events-your-area>

Case work

Person-centered approach

During times of uncertainty or heightened political tension, especially during Open Enrollment period and Medicare changes—a **person-centered approach** is essential. It helps us stay grounded in what matters most: the individual in front of us. Our role is to provide clear, unbiased information about Medicare—without letting personal beliefs interfere.

Medicare counseling is not about convincing someone of a viewpoint—it's about listening, understanding their unique situation, and providing accurate, unbiased information so they can make informed choices. In a politically charged environment, our neutrality, empathy, and focus on the beneficiary's goals help create a safe space where trust and clarity can thrive.

Counseling session preparation

Learning objective

By preparing for the call with a beneficiary, you will be equipped to provide them with accurate information, guidance, and support regarding their options.

Case

Robert is 62 years old, on Medicare for disability

Zip: 98117

Doesn't qualify for MSP

- Monthly income \$3200
- Married

Current prescriptions:

- Propranolol HCL ER (to prevent migraines) - 80 mg capsule - 1 per day
- Sumatriptan (for when he has a migraine)- 100mg tablet - 2 per week 9per month

- Topiramate (for seizure prevention) - 50 mg tablet - 2 per day

Current plan: AARP Medicare Advantage Essentials from UHC WA-7 (HMO-POS)

Current concerns:

- Lost primary care provider
- Needs chiropractor
- Needs dentures

You are preparing to call the client:

Question	Answer
What do you do to prepare for this session?	
What information do you need to convey?	
What would you consider to be in your scope for this session?	

Counseling session transcript

Lena - SHIBA Counselor: Hi, Robert, I'm Lena! Thanks for coming in. How can I help you?

Robert: Hi, Lena, I just got a notice from my plan that my doctor is not going to be in network and so I wanted to see how I can find out if a doctor or clinic is in network for my plan, and also kind of check my coverage for chiropractic care and dental. I have some issues coming up, and I just don't really know what my coverage even has in it. Or maybe if I should switch to something better for next year.

I'm just really kind of at a loss of what to do here.

Lena - SHIBA Counselor: Okay, that's understandable. So what we can do right now is look at your coverage for this year. Then, once Open Enrollment starts, you can do this for next year's plans to see if there, if a different plan offers more of what you want or need, does that sound? Okay.

Robert: Yeah, that'd be great.

Lena - SHIBA Counselor: Okay. So first, do you ever use Medicare.gov?

Robert: Yeah, I've used it a little.

Actually, I did notice that there is a option to look up care providers, you know, on the 1st screen when you log in is that something I can use to see if my providers are in network.

Lena - SHIBA Counselor: Well, that's gonna depend on what kind of Medicare coverage you have. Do you happen to know what Medicare plan you have?

Robert: Let me see what my card says.

Robert: It says I have an AARP Medicare Advantage Essentials from UHC WA-7.

Lena - SHIBA Counselor: Okay, that's a Medicare advantage plan. So you'll need to check with the company to verify whether doctors and or clinics are in network. You can do that on the company's website. But if you do always check with your medical provider as well.

Robert: Oh, okay.

Lena - SHIBA Counselor: Okay, I'm in the Medicare plan finder on Medicare on medicare.gov already. So I'm going to show you how to do this so that you can know how to get the information for any plan quite easily. So if you're looking into changing plans during open enrollment, and you want to be able to do this on your own.

You'll have the basics that you need if you're trying to compare plans. Does that sound good.

Robert: Yeah, sounds good.

Lena - SHIBA Counselor: Okay, so what is your Zip code?

Robert: 98117

Lena - SHIBA Counselor: Okay...and you have a Medicare advantage plan.

Do you get any assistance from the State paying your Part B premiums, or any reduced medication costs through what's called Extra Help?

Robert: No, I don't. I don't believe I do.

Lena - SHIBA Counselor: So we're just going to go in and look at your plan and the benefits.

And you said it's an AARP plan.

Robert: Yeah, that's right. Essentials.

Lena - SHIBA Counselor: Okay.

Robert: UHC WA-7

Lena - SHIBA Counselor: Okay. Let's see here...

Okay, I found it...just to verify on your card. Is there a Plan ID? It probably has a number like H-3805, and then a number behind that. That's 32.

Robert: Yeah.

Lena - SHIBA Counselor: Okay, great.

AARP Medicare Advantage Essentials from UHC WA-7 (HMO-POS)
UnitedHealthcare | Plan ID: H3805-032-0
Star rating: ★★★★★

MONTHLY PREMIUM

\$0.00 Includes: Health & drug coverage
Doesn't include: \$185.00 Standard Part B premium

TOTAL DRUG & PREMIUM COST (for the rest of 2025)

\$0.00 Only includes premiums for the months left in this year when you don't enter any drugs

OTHER COSTS

\$0.00 Health deductible
\$255.00 Drug deductible
\$5,900 In-network Maximum you pay for health services

PLAN BENEFITS

✓ Vision
✓ Dental
✓ Hearing
✗ Transportation
✓ Fitness benefits
✓ Worldwide emergency
✓ Telehealth
[See more benefits](#)

COPAYS/COINSURANCE

Primary doctor: \$0 copay
Specialist: \$0-30 copay per visit

DRUGS

[Add your prescription drugs](#)
Enter drugs you take regularly (if any) to see your estimated drug + premium cost

So, on the Medicare Plan Finder you can actually compare plans. And we can help you with this during open enrollment, or you can try to do it a little bit yourself and contact us if you have questions or concerns. It sounds like you've been on Medicare.gov, so you're a little bit familiar with it, in case you want to be able to do that and prepare yourself a little bit.

So, let's look at your plan for right now and see what it shows us.

<<Opens detail page for current plan>>

[Back to search results](#)

UnitedHealthcare

AARP Medicare Advantage Essentials from UHC WA-7 (HMO-POS)

Plan type: Medicare Advantage with drug coverage

Plan ID: H3805-032-0

[Plan website](#) | Non-members: 1-800-555-5757 | Members: 1-877-370-3249

What you'll pay

Total monthly premium

\$0.00

Health deductible

\$0.00

Primary doctor

\$0

copay

[Overview](#)[Benefits & Costs](#)[Drug Coverage](#)[Extra Benefits](#)[Optional Packages](#)[Star Ratings](#)

If we scroll down just a bit to the Benefits and Cost section.

You can click here and view the Provider Network Directory, and that's a direct link to the company's provider network (information) that you can check to see if your provider is in network for that plan. Every single plan has this (link) on the plan finder. So if you're trying to compare plans in the fall, you'd be able to do this for another plan.

So you said, you're looking for. We want to look at the chiropractic and the dental right.

Robert: Yeah, I've been getting migraines, and I've been really wanting to try out chiropractic care for that.

Lena - SHIBA Counselor: Okay.

Robert: I also really need to look at dental. I just had so much dental issues this last year that you know, I'm just considering, maybe just pulling them all out and looking at dentures.

Lena - SHIBA Counselor: Okay. Oh, my goodness, yeah, dental is a little hard. Right?

Robert: Yes.

Lena - SHIBA Counselor: Okay. So looking at the detail page on the plan finder, I can see that you have basic dental. But it looks like you don't have any comprehensive dental that would cover more extensive work. So what we're going to do is we're going to look at your evidence of coverage.

Every plan has a guide that explains the coverage in detail, and we're going to go. Look at that.

And you can get to this pretty easily at the top of (the page) if you're in the plan finder, and you can do this for any plan by going to the plan website, the link right up in the top, in the header. And it'll take you to that plan website. It might look a little different for different plans. But it basically always works the same.

<<On plan website>>

Lena - SHIBA Counselor: Okay? So you said, your Zip code is 9, 8, 1, 1, 7, right? We're going to view the plans.

It's showing us all the plans that are available. So here's your plan, and that's an HMO-POS, right?

AARP Medicare Plans from UnitedHealthcare 1-877-699-5710 Sign in

[Home](#) [Shop Medicare plans](#) [Learn about Medicare](#) [Member resources](#) [Your saved items](#)

Plans for **98117 King County** [Email](#) [Print](#)

[Back to Medicare options](#) **Medicare Advantage plans** [Medicare Supplement Insurance plans](#) [Medicare prescription drug plans](#)

Medicare Advantage plans available for 2025

Filter by: [Plan Type](#) [Coverage Type](#) [Special Needs](#) [Additional Benefits](#) [Cost Savings](#) [Clear all](#)

Showing 15 of 22 plans

AARP Medicare Advantage Extras from UHC WA-14 (HMO-POS)

Monthly premium: **\$0** Out-of-pocket maximum: **\$6,700**

[Enroll in plan](#) ☐ [Add to compare](#)

- Prescription drug coverage
- \$2,500 for covered dental services
- \$50 credit a quarter for OTC products
- \$300 eyewear allowance and eye exam
- Free gym membership
- Copays as low as \$99 for hearing aids

[Add your doctors & dentists to see if they are in network](#)

[Add your drugs to see estimated drug costs](#)

[View plan details](#)

AARP Medicare Advantage Essentials from UHC WA-7 (HMO-POS)

Monthly premium: **\$0** Out-of-pocket maximum: **\$5,900**

[Enroll in plan](#) ☐ [Add to compare](#)

- Prescription drug coverage
- \$0 copay for preventive dental
- \$40 credit a quarter for OTC products
- \$300 eyewear allowance and eye exam
- Free gym membership
- Copays as low as \$99 for hearing aids

[Add your doctors & dentists to see if they are in network](#)

[Add your drugs to see estimated drug costs](#)

[View plan details >](#)

AARP Medicare Advantage from UHC WA-12 (PPO)

Monthly premium: **\$0** Out-of-pocket maximum: **\$6,700**

[Enroll in plan](#) ☐ [Add to compare](#)

- Prescription drug coverage
- \$500 for covered dental services
- \$35 credit a quarter for OTC products
- \$300 eyewear allowance and eye exam
- Free gym membership
- Copays as low as \$99 for hearing aids

[Add your doctors & dentists to see if they are in network](#)

[Add your drugs to see estimated drug costs](#)

[View plan details >](#)

Robert: It. Yeah. It says that. Yeah.

Lena - SHIBA Counselor: Okay? And you've been okay with how that works for you, with the referrals and things like that.

Robert: Yeah, that that's been fine.

Lena - SHIBA Counselor: Okay. So we're going to go down to the bottom of this box. See where it says, view plan details. We're going to click on that.

And then we get a we get a summary of the plan and links for details for each plan individually, where we're only looking at the information for this plan, and we have costs and things like that, the basics. But if we go down we can always see somewhere on here plan documents and we're looking for the Evidence of Coverage. It might even have that listed separately.

AARP Medicare Advantage Essentials from UHC WA-7 (HMO-POS)
 You're viewing plan details for 98117 King County

Monthly premium: **\$0** Primary care provider (PCP): **\$0** copay Out-of-pocket maximum: **\$5,900** Estimated Annual Drug Cost: [Add your drugs](#)

[Cancel](#) [Save](#) ☐ Add to Compare

Discover the Benefits

- Dental benefits**
\$0 copay for network preventive dental including oral exams, x-rays, routine cleanings and fluoride
- OTC credit**
\$40 credit every quarter for OTC products like pain relievers, cold remedies and vitamins & more on online
- Routine vision benefits**
\$300 allowance for frames or contacts every 2 years, plus \$0 copay for routine eye exam and standard prescription lenses

General plan costs
 See how much you'll pay for this plan including your premium, deductible and maximum out-of-pocket costs.

Costs	What you'll pay
Monthly premium	\$0
Medicare Part B premium giveback ⓘ	Up to \$5
Annual medical deductible ⓘ	\$0
Out-of-pocket maximum ⓘ	\$5,900
National Network ⓘ	Yea, you can get network care across the country


Doctor visits
Find out about this plan's copays for primary care providers and specialists.

Prescription drug benefits
Learn about this plan's prescription drug coverage and costs. Enter your prescriptions to see what they'll cost with this plan.

Dental coverage
Learn about this plan's dental coverage options and costs.

Medical benefit information
See this plan's benefits, costs and copays. For full plan details, see the **Evidence of Coverage** or **Summary of Benefits** under the Plan Documents section.

Extra benefits and programs
See more of the benefits and programs offered by this plan that are not provided under Original Medicare. For full plan details, see the **Evidence of Coverage** or **Summary of Benefits** under the Plan Documents section.

Plan documents
Important documents that provide the details you need about this plan's coverage and benefits, prescription drugs, enrollment and more. 

Footnotes & disclaimers



Supporting you through your
Medicare journey

Chat with UnitedHealthcare
You can chat with us online.

[Chat now](#)

Call UnitedHealthcare
Call 1-877-899-5719 / TTY 711
Hours: 8 a.m. to 8 p.m., 7 days a week

Already a member?

Go to the member site to see your plan benefit information.
[Member sign in](#)

But as I expand on the plan documents, you can see we have Evidence of Coverage here. So I'm going to click on that, and it'll just open.

You should get one of these in the mail in September that you get a hard copy of it as well. If you've signed up for electronic communications, you'd get that as an attachment for an email or a link.

Extra benefits and programs

See more of the benefits and programs offered by this plan that are not provided under Original Medicare. For full plan details, see the **Evidence of Coverage** or **Summary of Benefits** under the Plan Documents section.



Plan documents

Important documents that provide the details you need about this plan's coverage and benefits, prescription drugs, enrollment, providers and more.

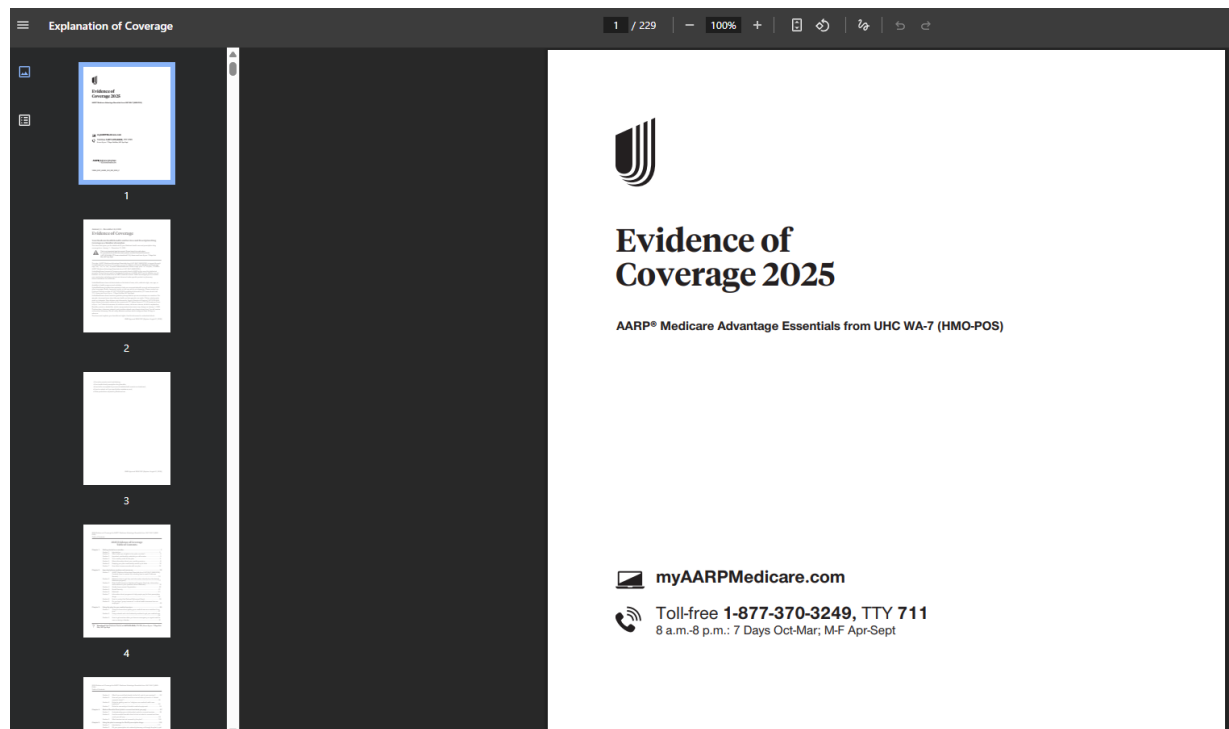


English

General Plan Information

- [Enrollment Form \(PDF\) \(Updated 03/23/2025\)](#)
- [Evidence of Coverage \(PDF\) \(Updated 05/26/2025\)](#)
- [Summary of Benefits \(PDF\) \(Updated 09/05/2024\)](#)
- [Star Ratings \(PDF\) \(Updated 01/01/2025\)](#)
- [Benefit Highlights](#)
- [Annual Notice of Changes \(ANOC\) \(PDF\)⁵](#)

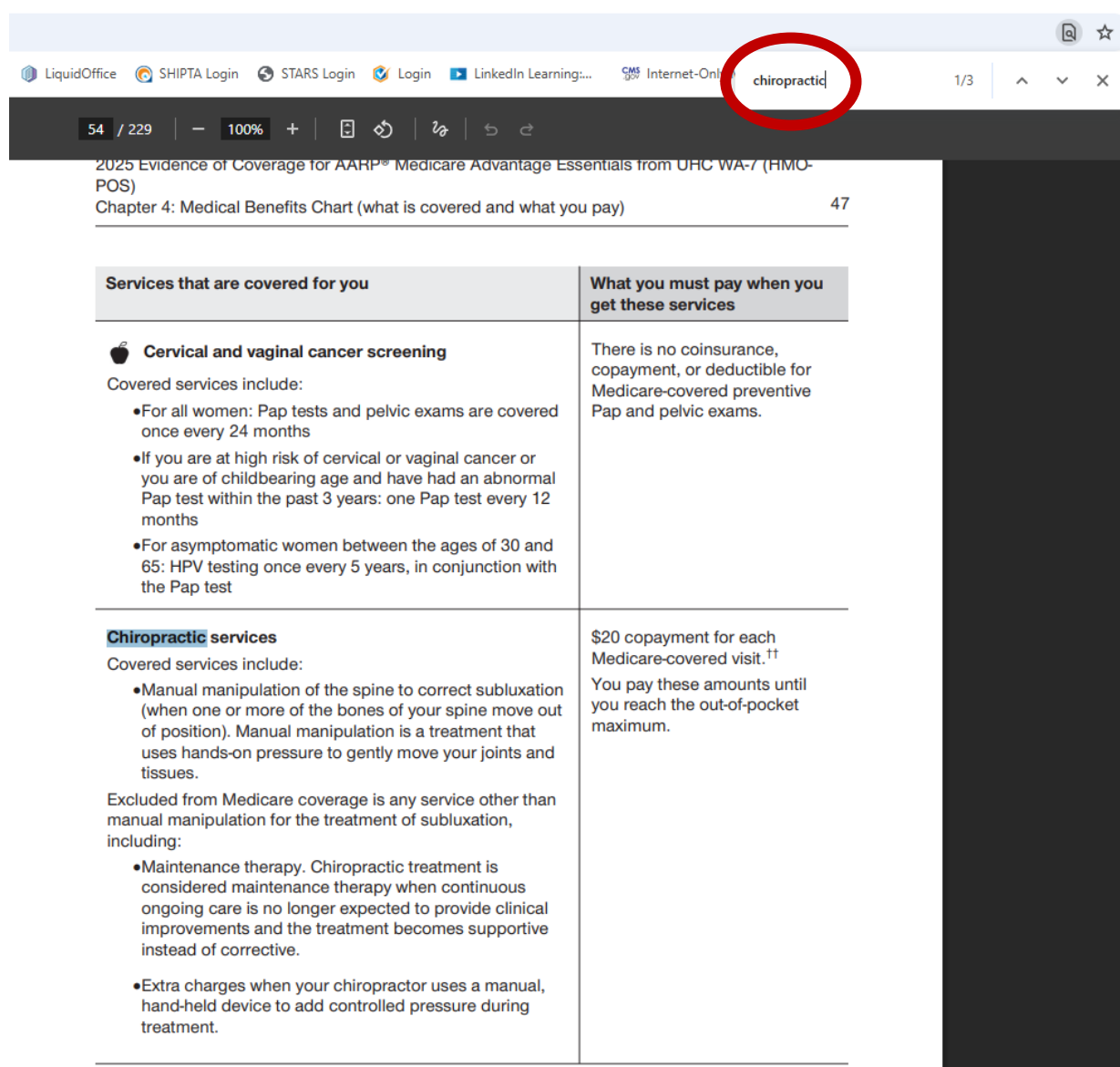
There's also a Summary of benefits that can be helpful. But it doesn't have quite as many details. So we're going to look at this one today.



So, as you get into this (Evidence of Coverage) you can find things in the table of contents, but it's pretty extensive.

And it can be a little bit confusing on finding what you're looking for. So, I'm gonna show you a shortcut. You might already be familiar with this. But just in case you're not.

It's my favorite. I hold down the control (CTRL) button and hit the F, and you can see a little search button just came up. I'm going to start with chiropractic because that tends to be more straightforward.



54 / 229 | 100% | Search | 1/3

2025 Evidence of Coverage for AARP® Medicare Advantage Essentials from UHC WA-7 (HMO-POS)
Chapter 4: Medical Benefits Chart (what is covered and what you pay) 47

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none">•For all women: Pap tests and pelvic exams are covered once every 24 months•If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months•For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: <ul style="list-style-type: none">•Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: <ul style="list-style-type: none">•Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective.•Extra charges when your chiropractor uses a manual, hand-held device to add controlled pressure during treatment.	\$20 copayment for each Medicare-covered visit. ^{††} You pay these amounts until you reach the out-of-pocket maximum.

And here we are on your chiropractic services that are covered by your current plan.

And you can see it covers manual manipulation of the spine to correct subluxation, and it shows what's excluded maintenance therapy. So it has to be correcting something right, and there can be extra charges. When a chiropractor uses a manual handheld device, you'll have a \$20 copayment for each of the visits. So it has the details of that coverage in here you get a pretty good idea, and if you have more questions, you can always call the company and ask.

Robert: Okay.

Lena - SHIBA Counselor: So did you see, did you get how that worked? Okay?

Robert: Yeah. The CTRL + F search feature.

Lena - SHIBA Counselor: Yeah. Yeah. And so we looked on the plan finder and saw that you had to have basic dental. But it looks like you don't have comprehensive dental, or, you know, for more extended care. So what I'm going to do, you said you might need dentures right? So I'm going to type in dentures, because that's something that can be a little trickier for the coverage, so it would probably be part of comprehensive dental.

Not that preventive dental right? So I typed in dentures, because that's a more relevant keyword. And it's taken us down to page 108 of the explanation of benefits, and we see it looks like to get dentures covered. You need to get the platinum dental rider, and that's dental coverage that you add to your Medicare advantage plan.

Introducing the Platinum Dental Rider

We know that having choices in selecting health care benefits is important to you. The Platinum Dental Rider is an optional supplemental benefit package that can be purchased to replace any dental benefits that may already be offered within your Medicare Advantage plan. **The Platinum Dental Rider cannot be combined with any other dental benefits that may be included in your plan. It is offered to you for a monthly premium of \$54.00.** This is in addition to any plan premium you may have for your Medicare Advantage plan.

Covered Platinum Dental Rider Benefits:**Annual Maximum: \$1,500**

- Exams
 - Cleanings (prophylaxis & periodontal maintenance)
 - X-rays
 - Fillings
 - Crowns
 - Bridges
 - Root canals
 - Extractions
 - Partial dentures
 - Complete dentures
- \$0 copay for preventive and diagnostic dental care such as exams, routine cleanings, x-rays, and fluoride.
 - A 50% coinsurance applies to dentures and bridges (coinsurance applies to the actual dentures and bridges, not to modifications and adjustments for existing dentures or bridges).
 - All other covered comprehensive services are offered at a \$0 copay (including modification and adjustments to dentures and bridges).
 - All covered services have applicable frequency limitations. Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist or see the full list of covered dental services with associated frequency limitations, you can find it in the UHC Dental Medicare quick reference guide at uhcmedicaredentalproviderqrg.com
 - Procedures used for cosmetic-only reasons (tooth bleaching/whitening, veneers, gingival recontouring, enamel microabrasion), orthodontics, space maintenance, implants and implant-related services, sales tax, charges for failure to keep appointments, dental case management,

Lena - SHIBA Counselor: It's \$54 a month. Then it has a \$1,500 maximum, and we can see that full dentures and partial dentures are included in here, as well as extractions and some of the other work that you might need to be able to get dentures. Okay?

And then it also is showing us here that that would have a \$50 copay. You'd probably want to talk to the company about more details than that, right? But there it is.

And you should get that book in the mail or in your email sometime before October first, and then you can also look. You should get it sometime in September, and then on October, once we get to October first you can actually view next year's Plans on the Medicare Plan Finder.

Robert: Okay.

Lena - SHIBA Counselor: All right. Do you have any other questions?

Robert: No, no, for now it just looks like I have some research to do, and I guess I just wait for that new book to come out and see what they'll cover for next year. But this it's given me a really good start. It's been very helpful. Thank you.

Lena - SHIBA Counselor: You're welcome, and please call if you need help during open enrollment. This is one of the things that we do...actually help people compare plans for open enrollment.

Robert: Thank you. I will, all right. Have a good day.

Counseling session critique & coaching:

What did they do well?	What can they do better next time?
<i>Technical:</i>	
<i>Relational:</i>	

STARS

STARS Beneficiary Contact Form (BCF) notes

We urge you to appreciate the importance of detailed comments in your BCFs. Thorough documentation is key to maintaining the quality and continuity of the service we provide to our beneficiaries in counseling sessions.

Activity: STARS data entry

Discussion:

- During busy season what are some tips and tricks you use to stay current on STARS?

- How do you prioritize data entry when you have back-to-back appointments?

Senior Medicare Patrol anti-fraud & abuse tips for a safe OEP

SMP Mission: "To empower and assist Medicare beneficiaries, their families, and caregivers to **prevent, detect, and report** health care fraud, errors, and abuse through outreach, counseling, and education."

SHIBA and SMP are working together to help consumers across Washington state.

Seven Common Fraud Schemes During Medicare Open Enrollment

During the Medicare OEP, beneficiaries often compare plan options and may need to share personal, health, and identification information as part of the process. However, this does **not** mean information should be shared with everyone who asks. Advisors should remind beneficiaries to protect their information and be alert for common fraud schemes.

1. **"New Medicare cards are being issued."**

The truth: Medicare issued new cards in 2018 and has no plans to issue them again.

Tip: If new to Medicare, beneficiaries will receive their card **only after** enrollment, inside their official *Welcome to Medicare* packet.

2. **"Your Medicare is about to be cancelled, and we need to verify your information."**

Scam callers may use fear to get a beneficiary's Medicare ID number, date of birth, Social Security number, or banking details.

The truth: Medicare does not call beneficiaries unless a call was requested and will not threaten cancellation or request ID information as they already have that.

Tip: If worried about coverage, beneficiaries should call **1-800-633-4227** (Medicare) directly or SHIBA for help setting up a secure Medicare online account.

3. **“You are preapproved for a better, cheaper plan.”**

The truth: “Preapproval” tactic is used to obtain personal and Medicare information. Even if enrollment occurs, the plan may not be suitable and could fail to cover the beneficiary’s providers, prescriptions, or services.

Tip: Beneficiaries should verify coverage using the official Medicare Plan Finder or with the help of a trusted SHIBA counselor.

4. **“You are eligible for a refund for overpayment of benefits.”**

The truth: Scammers use this “promise” scheme to capture banking information for a refund that will never be issued. If it sounds too good to be true, it likely is not real.

Tip: Beneficiaries should never provide bank account details to unknown or unsolicited contacts.

5. **“You qualify for free medical supplies”** — often framed as offers for braces, genetic testing, or similar items.

The truth: Such calls are typically attempts to obtain Medicare ID numbers.

Tip: Beneficiaries should confirm eligibility for supplies directly with their plan or, for Original Medicare, through their doctor and a Medicare-contracted supplier.

6. **“Our plan is preferred by Medicare.”**

The truth: Medicare and Medicaid never endorse or prefer specific plans.

Tip: Beneficiaries should be cautious of any claims suggesting Medicare approval or recommendation.

7. **“Spoof” websites.**

The truth: Some fraudulent websites are designed to look like legitimate Medicare or plan sites but collect personal data. Fraudulent sites often redirect visitors to scam pages, sometimes outside the U.S., where personal information can be stolen.

Tip: Beneficiaries should enter official web addresses (such as Medicare.gov) directly into their browser instead of clicking links from emails or ads.

Counselor Corner: OEP Fraud Prevention

Advisors should encourage beneficiaries to:

- Keep their Medicare card and number secure and share them only with trusted providers or plans.
- Avoid engaging with unsolicited calls requesting personal or Medicare information.
- Confirm offers or requests directly with Medicare or SHIBA before taking action.
- Refrain from clicking links in emails, texts, or ads claiming to be from Medicare.
- Review plan coverage to ensure providers, pharmacies, and prescriptions are included.
- Report any suspected fraud to Senior Medicare Patrol or Medicare without delay.

Marketing and Agent Behavior — What's Not Allowed

During OEP, beneficiaries may be targeted by TV ads, online promotions, or unsolicited phone calls promoting specific plans.

Counselor Corner: Illegal practices

Advisors should make beneficiaries aware of prohibited practices, including:

- High-pressure tactics to rush plan changes.
- Offers of cash, gifts, or rewards to switch plans.
- Attempts to charge a fee for plan enrollment.

These actions are illegal under Medicare rules, and beneficiaries should disengage from any situation that involves pressure, urgency, or suspicious claims.

Final reflections

Learning outcomes

Do you have a clear understanding of the Medicare changes for 2026?

Do you feel better prepared to effectively counsel Medicare beneficiaries during Open Enrollment Period?

How can SHIBA staff help?

Contact your RTC:

- Brisson, Noreen (OIC) Noreen.Brisson@oic.wa.gov
 - Office 509-818-1017
 - Cell 360-349-2850
- Dieckman, Lynda (OIC) Lynda.Dieckman@oic.wa.gov
 - Office 360-725-7257
 - Cell 360-742-4949
- Lee, Rosie (OIC) Rosie.Lee@oic.wa.gov
 - Office 360-725-7253
- Skye-Dugovich, Shannon (OIC) Shannon.Skye-Dugovich@oic.wa.gov
 - Office 360-725-7108
 - Cell 360-250-4900
 - Cell 360-701-0933
- Stones, Sam (OIC) Sam.Stones@oic.wa.gov
 - Office 206-389-2916
 - Cell 360-250-6995

For fraud related issues

Contact Senior Medicare Patrol Coordinator Kim McKenna

kim.mckenna@oic.wa.gov

For any curriculum & training related questions & suggestions:

Contact SHIBA Curriculum & Training Coordinator, Elena Garrison
OICMedicareTrainingFeedback@oic.wa.gov or call: **360-725-7107**

Thank you for your participation.

Appendix A

Who do I contact –Social Security or Medicare?¹⁷

Topic	Social Security	Medicare	Resources
 How do I report a death?	X		Contact your local Social Security Office or call 1-800-772-1213 (TTY 1-800-325-0778)
 How can I check Medicare eligibility?	X		ssa.gov/medicare
 What does Medicare cover?		X	medicare.gov/what-medicare-covers
 How do I sign up for Hospital Insurance? (Part A)	X		ssa.gov/medicare
 How do I sign up for Medical Insurance? (Part B)	X		ssa.gov/medicare
 How do I apply for Extra Help with Medicare Prescription drug coverage? (Part D)	X		ssa.gov/medicare/part-d-extra-help
 How can I check the status of Medicare Part A or B claims?		X	medicare.gov/account/login
 Where do I find forms for filing a Medicare appeal or let someone speak with Medicare on my behalf?		X	medicare.gov/claims-appeals/how-do-i-file-an-appeal
 How do I appeal an income-related monthly adjustment amount decision? <i>(for people who pay a higher Part B or D premium because income is over a certain amount)</i>	X		ssa.gov/benefits/medicare/medicare-premiums.html
 How can I request a replacement Medicare card? <i>(with a my Social Security or Medicare account)</i>	X	X	ssa.gov/myaccount medicare.gov/account/login
 If I already get benefits or have Medicare, how do I report a change of address or phone number?	X		ssa.gov/myaccount
 What do Medicare health and prescription drug plans in my area cost, and what services do they offer?		X	medicare.gov/plan-compare
 Which doctors, health care providers, and suppliers participate in Medicare?		X	medicare.gov/care-compare/
 Where do I find publications about Medicare?	X	X	ssa.gov/pubs/?topic=Medicare medicare.gov/publications
 Where can I find out more about a Medicare prescription drug plan (Part D) and enroll?		X	medicare.gov/drug-coverage-part-d/how-to-get-prescription-drug-coverage
 Where can I find a Medicare Supplement Insurance (Medigap) policy in my area?		X	medicare.gov/medigap-supplemental-insurance-plans

¹⁷ <https://www.ssa.gov/pubs/EN-05-10500.pdf>

Appendix B¹⁸

Medicare.gov account

User guide

Shop for Plans Using Your Medicare Account

Medicare

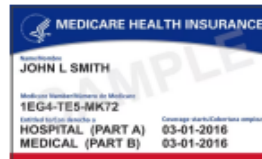
If you create a Medicare account, you get access to personalized features when you shop for plans at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare). You'll be able to:

- Get a summary of your current coverage.
- Review how your current plan will change next year (available during Open Enrollment).
- Compare your current plan to other plans in your area.
- Manage a list of your prescription drugs and preferred pharmacies.
- Get detailed cost information that includes any help you get (like from a Medicare Savings Program or Extra Help).

Ready to get started?

Visit [Medicare.gov/account/login](https://www.medicare.gov/account/login). You'll need the following information (for yourself or the person you're helping):

1. Medicare Number – This is on the front of your red, white, and blue Medicare card.
2. Part A or Part B coverage start date – This is on the front of your red, white, and blue Medicare card.
3. Personal information – Like your name, date of birth, and current address.



After you enter your information and select "Next," create your username and password. To help you remember your username and password, you can write them in the spaces below. Keep this sheet in a safe place to protect your privacy.

My username:

My password:

Forgot your username or password?

If you already have an account, visit [Medicare.gov/account/login](https://www.medicare.gov/account/login) and select "Forgot your username or password?" to get or reset your login information.



Medicare

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

This product was produced at U.S. taxpayer expense.

CMS Product No. 12064 • 09/2024

¹⁸ <https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/12064 Using Your Medicare Account-508.pdf>

Appendix C

OEP worksheet: Gather basic information

Beneficiary's name: _____

DOB _____

Beneficiary's zip code _____

2025 Plan Name: _____

PDP ☐ MA-PD ☐ None – in other creditable coverage (see below)

Beneficiary's effective dates:

- Part A Effective Date _____
- Part B Effective Date _____
- Medigap Policy Name _____
- Other prescription drug coverage? _____

➤ Is the other prescription drug coverage:

- ☐ Employer-sponsored health insurance
- ☐ Federal Employee Health Benefits Program (FEHBP)
- ☐ VA or TRICARE for Life

Name of Policy: _____

** Is this "other" coverage creditable drug coverage? Yes No

Appendix D

Checklist for counselors to help beneficiaries shop for Part D plans and screen for LIS/Extra Help

Step 1: Screen for LIS & MSP

- Is the beneficiary enrolled in LIS/Extra Help in 2025? ☐ Yes ☐ No
(Note: Can check status in Medicare Plan Finder if client has a registered [MyMedicare.gov](https://www.medicare.gov) account and log-in)
- If not enrolled, is the beneficiary willing to screen for eligibility? ☐ Yes ☐ No
 - If yes, record the following information:
 - ✓ Monthly Income:
\$ _____
 - ✓ Resources (if income is above MSP level):
\$ _____
 - Marital status: ☐ Single ☐ Married

Step 2: Use the [Medicare Plan Finder](#) tool

- Baseline: Current plan (refer to Current Medications List below)
 - a. Coverage in 2025 for current drugs in current plan
 - b. Pharmacy: _____
In network? ☐ Yes ☐ No

Current Medications List:

Name of Drug	Generic? (Y/N)	Strength and dose (Ex: 30 mg taken twice a day)
1.		
2.		
3.		

4.		
5.		
6.		

- Review pertinent sections of current plan Annual Notice of Change (ANOC)
- Record how costs will change for the beneficiary in 2026:

Premium: 2025: ____ 2026: ____

Deductible: 2025: ____ 2026: ____

Copay/coinsurance: ____

Is the formulary changing in 2026? If yes, for which drugs?

Step 3: Discuss MA-PD vs. PDP

Step 4: Run comparison by cost, drug coverage, and utilization management

How Beneficiary is Enrolled (no later than Dec. 7, 2025):

Date of enrollment: _____

☐ Plan Finder

☐ Paper application mailed to plan

☐ Enrollment confirmation number

Note: Can print out and give a copy to beneficiary, retaining a copy in your file

☐ Call plan

Note: Not recommended as no way to retain proof of enrollment action

Appendix F

Medicare Plan Documents & Notices – Summary Table

Document/ Notice	What it is	When it's sent	What to look for / Key points
ANOC (Annual Notice of Change)	Summary of upcoming changes to the Medicare Advantage or Part D plan for the next year.	September- October	<ul style="list-style-type: none"> - Changes to premiums, copays, deductibles - Network updates (providers, pharmacies) - Formulary (drug list) changes
EOC (Evidence of Coverage)	Detailed explanation of coverage, benefits, and costs; acts as a contract between the plan and beneficiary.	Typically mailed with ANOC	<ul style="list-style-type: none"> - Full list of benefits and rules - Important for understanding specifics of plan coverage
EOB (Explanation of Benefits)	Summary of services used and how the plan handled payment; not a bill.	Usually monthly, after services	<ul style="list-style-type: none"> - Services received - Amount billed, paid, and owed - Accessible online as well
Network Changes	Notification that an in-network provider has left the plan's network.	At least 30 days before change	<ul style="list-style-type: none"> - Only if the beneficiary regularly uses that provider - May affect costs and access

Document/ Notice	What it is	When it's sent	What to look for / Key points
Mid-Year Formulary Changes	Updates to the plan's list of covered drugs.	Mid-year, as needed	<ul style="list-style-type: none"> - May affect drug coverage or pricing - Beneficiaries may have appeal or transition rights

References

Centers for Medicare & Medicaid Services

Fact Sheet: Medicare Prescription Payment Plan Final Part Two Guidance.

<https://www.cms.gov/files/document/fact-sheet-medicare-prescription-payment-plan-final-part-two-guidance.pdf>

Guide to consumer mailings from CMS, Social Security, and plans in 2024/2025

<https://www.cms.gov/medicare/prescription-drug-coverage/limitedincomeandresources/downloads/consumer-mailings.pdf>

Using Your Medicare Account

https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/12064_Using_Your_Medicare_Account-508.pdf

Original Medicare Prior Authorization

<https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare#:~:text=CMS%20Launches%20New%20Model%20to%20Target%20Wasteful%2C%20Inappropriate%20Services%20in%20Original%20Medicare.&text=The%20WiSeR%20Model%20will%20test%20a%20new,fraud%2C%20waste%2C%20and%20abuse%2C%20or%20inappropriate%20use.>
<https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#print>

Wasteful and Inappropriate Service Reduction (WiSeR) Model Office Hour:

<https://www.youtube.com/watch?v=CATxta1fFu4>

References (cont.)

Federalregister.gov

Medicare and Medicaid programs contract year 2026 policy and technical changes to the Medicare

<https://www.federalregister.gov/documents/2025/04/15/2025-06008/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare>

Medicare program implementation of prior authorization for select services:

<https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and#print>

Justice in Aging

What's in the Budget Reconciliation Act of 2025 and What Does it Mean for Low-Income Older Adults' Access to Health and Long-Term Care?

<https://justiceinaging.org/budget-reconciliation-and-low-income-older-adults/>

Medicaid Defense

<https://justiceinaging.org/series/medicaid-defense/>

Medicare Interactive

Notices of change

<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>