OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Training

Statewide Health Insurance Benefits Advisors (SHIBA)

January Update

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

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Core/monthly training topics

Q1	Q2	Q3	Q4
January • Keeping it light – coming off of OEP • Recap best practices – what is working, how are you doing, etc. • Annual disenrollment • Troubleshooting after OEP • A&B coverage and costs • Medigaps • Part D – Extra Help • Other	**April – VC/Vol conference** Are we going to have a VC? If so, **no monthly training**. • Volunteer Recognition • Other *Conference may be in May. If so, will switch around – keeping same topics.	**July** • Fraud and abuse • OEP outreach event planning • Disabilities • Other	**October** • Review Part D and MA plans • Other
February • Other coverage options – aka - coordination of benefits, i.e., Tricare, PEBB, etc. • Contract/Performance – how is it counted • Other	**May -** Menu of online courses on My SHIBA • Medicaid • Transition from Apple to Obamacare • Other	**August** - Off	**November** • Late-breaking news for OEP • Check-in, support and troubleshooting • Other
March Volunteer counseling tools and tips – SHIBA Online, ordering pubs, Unique ID, etc. • FPL chart • Complaint process • Other	**June** • Counseling technique for people new to Medicare • Other	**September – OEP focus** • OEP prep • CSS training • Other	**December** - Off

Review 2015 OEP

Happy New Year!

Looking back in 2015 your accomplishments are outstanding. Here are some milestones that have reflected your achievements during this year's Medicare OEP. We have exceeded last year's numbers in the following areas.

As of December 7, 2015, we accomplished:

- **18, 617 CCRs** – that's a 14% increase from 2014 (The number of CCRs listed may be skewed due to deferred entries of CCRs)
- **30,315 PMAs** - that's a 15% increase from 2014
- **6,335 call volume** – that's a 45% increase from 2014

With these outstanding accomplishments, we would like to collect input from SHIBA volunteers, staff and anyone involved in helping Medicare clients. This will help us challenge ourselves to the next level for 2016. Please provide your input in the following questions:

What worked?

What didn't work?

How are you doing?

What can we improve on for 2016?

-- Please give feedback to trainer, so we can discuss at next trainers meeting --

Clients Whose MA/MAPD Plan Ended or who Failed to Pick a New One

- **Clients may join a stand-alone Part D plan or a different Medicare Advantage (MA) plan (MA Non-Renewal Special Enrollment Period)**
  - Special Enrollment from January 1 – February 28, 2015
- **Guaranteed issue to buy a Medigap with no health screening**
  - Up to 63 days after old plan ends
  - If clients join a Medigap, and they want Rx coverage:
    - They should sign up for a Part D plan
  - Share with the client the *MA Enrollment Timelines:*
    - Publication # SHP 811 (**top of page 3**)

Clients Who Want to Leave Their MA Plan

- **Clients may leave their plan during the Medicare Advantage (MA) Disenrollment Period from January 1 – February 14**
  - Share with the client the *MA Enrollment Timelines*
    - Publication # SHP 811 (**bottom of page 2**)
  - Clients **must** go to Original Medicare
  - Clients may not get a different MA plan
  - Clients may get a stand-alone Part D plan (we can help them find one that meets their needs)
- **After February 14:**
  - Clients may leave if they have a Special Enrollment Period
    - See Understanding Medicare Part C & D Enrollment Periods, CMS Publication # 11219 http://www.medicare.gov/pubs/pdf/11219.pdf
    - The client or you (the volunteer) may call Medicare for details
  - Clients may have to wait until the Medicare Open Enrollment Period (October 15 – December 7) to switch for 2017

Clients Who Missed Their Medicare Initial Enrollment Period

- **Clients who missed their Medicare Initial Enrollment Period and are NOT eligible for a Special Enrollment Period (SEP) may join Original Medicare Parts A and B from January 1 – March 31. This is called the General Enrollment Period.**
    - Coverage starts July 1, and these clients likely will have a late-enrollment penalty
        - Clients may also have a lapse in health coverage
    - Clients will have a SEP to join Part D or a Medicare Advantage Plan from April 1 through June 30
        - See Understanding Medicare Part C & D Enrollment Periods, CMS Publication # 11219 (**bottom of pages 3 & 11**) http://www.medicare.gov/pus/pdf/11219.pdf

5-Star Special Enrollment Period

- **Clients can switch to a Medicare Advantage (MA) plan that has 5 stars for its overall rating from December 8 – November 30**
    - Clients can only join an MA plan if one is available in their area
    - Clients can go from a 5-star to 5-star MA plan
    - If clients have an MA plan that is less than 5 stars, they can pick a new MA plan with 5 stars
    - Clients can only use this Special Enrollment Period once during the above timeframe
- **Clients may lose their prescription drug coverage if they move from an MA plan that has drug coverage to a 5-star MA plan that does not**
    - Clients will have to wait until their next OEP to get drug coverage

NOTE: Group Health Cooperative has lost their 5-star status for 2016

Changes Related to MA Plans' Provider Network

Beginning in 2016:

- **Notice from Plan to CMS**
  - Plans must notify CMS at least 90-days prior to significant provider network changes for no cause
    - Affected enrollees may be eligible for an SEP
- **Notice to MA Plan Enrollees**
  - Plans must provide enrollees at least 30 days advance notice of significant network changes
  - New language in Annual Notice Of Change/Evidence Of Coverage will explain enrollee rights to provider network changes each September

What to do When a Drug is Not Covered in 2016

- **Clients should work with their plan, their health care provider, or their pharmacy**
  - They can ask the plan for a "**transitional supply**" of their current drug
    - This is a temporary supply – up to 30-days to allow time to sort out the problem
  - They can check if there is a different drug they can take that is on their plan's formulary
  - They can request an exception
    - An exception is coverage of a drug that is not on the plan's formulary, such as the brand-name version of a generic drug
  - Clients should contact their plan or their pharmacy for assistance

Extra Help/Medicaid Clients Who Can't Get Their Prescriptions Filled

- **If clients have LIS, they may need to bring certain things to their pharmacy**
  - Medicare number
  - LIS letters from Social Security
  - Medicaid ("ProviderOne") card or award letter
  - Other documentation showing LIS eligibility
- **If clients are new to LIS, they may need to ask their pharmacy to call LINET at 1-800-783-1307 or they may go online to** *http://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html*
  - If the pharmacy will not allow this, the client may need to go to a different pharmacy
  - Client may also contact SHIBA for assistance and we can help find and join a Part D plan that meets their needs
- **If clients recently switched Part D plan, they may need to bring to the pharmacy any information about the new plan**
  - Paperwork **OR**
  - Electronic confirmation from medicare.gov
- **If clients have less than a three-day supply of drugs, consult with your Volunteer Coordinator, Regional Training Consultant, or fully complete Section 5 of the CCR (complaint section) and close the CCR**
- **If client is determined ineligible, he/she may be responsible for the cost of the claims**
  - Unless they can provide proof of eligibility for Extra Help

2016 Medicare Hospital Insurance (Part A) Covered Services

Services	Benefit	Medicare Pays	You Pay
Hospitalization Semi-private room and board, general nursing and other hospital services and supplies (Medicare payments based on benefit periods) *(See comments 1 & 2*)	First 60 days	All but $1,288	$1,288
	61st to 90th day	All but $322/day	$322/day
	91st to 150th day *(60 reserve days may be used only once)*	All but $644/day	$644/day
	Beyond 150 days	Nothing	All costs
Skilled Nursing Facility Care Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies (Medicare payments based on benefit periods) (*See comments 1 & 2*)	First 20 days	100% of approved amount	Nothing
	Next 80 days	All but $161/day	up to $161/day
	Beyond 100 days	Nothing	All costs
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements for home health care benefits	100% of approved amount 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
Hospice Care Pain relief, symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care
Blood♦ When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	For first 3 pints

1 - Neither Medicare nor Medigap insurance pay for most nursing home care (See *Medicare & You* booklet, page 39).

2 - A benefit period starts the first day you receive a Medicare-covered service in a qualified hospital. It ends when you've been out of a hospital (or other facility that provides skilled nursing or rehab services) for 60 days in a row. It also ends if you stay in a facility (other than a hospital) that provides skilled nursing or rehab services, but do not receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period starts.

♦ If the hospital gets blood from a blood bank at no charge, you won't pay for replacing it. If the hospital buys blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Premium for Part A: Most people don't pay a premium, because they (or their spouse) worked for over 40 quarters. If you have fewer than 30 quarters of coverage, you pay $411/mo. For 30-39 quarters of coverage, you pay $226/mo.

2016 Medicare Medical Insurance (Part B) Covered Services

Services	Benefit	Medicare Pays	You Pay
Medical Expenses Doctor services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, most outpatient mental health services, and other services	Unlimited if medically necessary	80% of approved amount (after $166 deductible)	$166 deductible,* plus 20% of approved amount and limited charges above approved amount**
Clinical Laboratory Services Blood test, urinalysis, and more	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services	Unlimited as long as you meet Medicare requirements	100% of approved amount: 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount* for durable medical equipment
Outpatient Hospital Treatment Services for the diagnosis or treatment of an illness or injury	Unlimited if medically necessary	Medicare payment to hospital based on hospital costs	20% of billed amount*
Blood♦	Unlimited during a benefit period if medically necessary	80% of approved amount (after $166 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount for additional pints♦*

* After you pay the yearly deductible of $166, you typically pay 20% of the Medicare-approved amount for most doctor services, outpatient therapy and durable medical equipment for the rest of the year.

** Federal law limits charges for physician services.

♦ If the hospital gets blood from a blood bank at no charge, you won't pay for replacing it. If the hospital buys blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Monthly Part B premium: Most people will pay $104.90 due to no cost-of-living increase for Social Security, while others not subject to the "hold harmless" provision will pay $121.80. Based on income, some clients will pay: $170.50, $243.60, $316.70 or $389.80.

We attempt to provide the most current information possible. Due to frequent changes, always check with Medicare at www.medicare.gov or at 1-800- MEDICARE (1-800-633-4227) for the latest premiums and deductibles. If you want personalized help, call SHIBA at 1-800-562-6900 and ask to speak with a SHIBA counselor in your area.

January 2016 Approved Medicare Supplement (Medigap) Plans

By federal law, the high-deductible plan F has a $2,180 deductible for the year 2016

People who:

- Have a Medigap plan B through N can join any Medigap plan – except Plan A.
- Have Medigap Plan A can join any Medigap Plan A.
- Have more comprehensive health coverage than the Medigap plan they're buying, can join any comprehensive Medigap plan – except Plan A.

There's no yearly open enrollment period for Medicare Supplement (Medigap) plans. You may apply to buy or switch plans at any time. However, outside of special enrollment periods, insurers may require you to pass a written health screening. Not sure whether you will need to take a health screening? Call our Insurance Consumer Hotline at 1-800-562-6900 and ask for a health compliance analyst.

Company	Pre-X[1]	Health screen[3]	Standardized Benefit Plans & Costs									
ASURIS NORTHWEST HEALTH[2] 1-866-704-2708			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$131		$183		$184		$100			
Notes about Asuris Northwest: These plans are offered in the following counties: Adams, Asotin, Benton, Chelan, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman counties.												
COLONIAL PENN[2] 1-800-800-2254			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$219	$267			$296	$273	$102	$177	$238	$173
With a high deductible	No	Yes					$72					
ASSURED LIFE ASSOCIATION 1-888-397-7786			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$204	$221	$275	$226	$276	$229				$198

Note: Plans and premium rates listed are filed and approved by the Washington State Office of the Insurance Commissioner. **Companies may change their rates at various times throughout the year, so always check with the company for the latest availability and premiums. Plans issued before June 1, 2010 have different rates due to changes in Medicare.** The appearance of a company on this list does not constitute an endorsement of a company or its policies by the Washington State Office of the Insurance Commissioner, SHIBA, or its volunteers.

Questions? Call our Insurance Consumer Hotline at 1-800-562-6900

January 2016 Approved Medicare Supplement (Medigap) Plans

Company	Pre-X[1]	Health screen[3]	Standardized Benefit Plans & Costs									
GERBER 1-877-778-0839			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$187				$260	$222				
GLOBE LIFE 1-800-801-6831			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$96	$156	$180		$182					
With a high deductible	Yes	Yes					$44					
GOVERNMENT PERSONNEL MUTUAL 1-877-778-0839			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$155		$213		$216	$177				$157
HUMANA[2] 1-800-498-1264			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$191	$208	$237		$242		$111	$159		$149
With a high deductible	Yes	Yes					$78					
KPS HEALTH PLANS 1-800-552-7114			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$135				$251		$87			$141
LOYAL AMERICAN[2] 1-866-459-4272			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$178				$219	$190				$154
PREMERA BLUE CROSS[2] 1-800-752-6663			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$151				$188					$149
With a high deductible	Yes	Yes					$80					

January 2016 Approved Medicare Supplement (Medigap) Plans

Company	Pre-X[1]	Health screen[3]	Standardized Benefit Plans & Costs									
REGENCE BLUECROSS BLUESHIELD OF OREGON[2] 1-800-258-3590			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$149		$209		$210		$113			
Notes about Regence BlueCross BlueShield of Oregon plans: These plans are available only to Clark County residents.												
REGENCE BLUE SHIELD[2] 1-888-734-3623			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$131		$183		$184		$100			
Notes about Regence Blue Shield plans: These plans are offered in the following counties: Clallam, Cowlitz, Columbia, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.												
SENTINEL 1-888-510-0668			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$199	$222	$275	$237	$278					
STANDARD LIFE[2] 1-888-290-1085			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	221	267	313	$230	$314	$232				$176
With a high deductible	No	Yes					$46					
STATE FARM INSURANCE (Call local agent)			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$146		$220		$222					
TRANSAMERICA[2] 1-866-205-9120			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$110	$145	$172	$159	$173	$159	$79	$118	$145	$136
TRANSAMERICA PREMIER 1-888-272-9272			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$120				$205	$182				$156

January 2016 Approved Medicare Supplement (Medigap) Plans

Company	Pre-X[1]	Health screen[3]	Standardized Benefit Plans & Costs									
UNITED AMERICAN 1-800-331-2512			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	Yes	Yes	$146	$202	$244	$230	$245	$213				$194
With a high deductible	Yes	Yes					$44					
Under age 65 Medicare disability	Yes	Yes		$392								
UNITEDHEALTHCARE (AARP)[2,4] 1-800-523-5800			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$115	$164	$194		$194		$57	$112		$128
Medicare Select Plan*	No	Yes			$189		$190					
UNITED OF OMAHA 1-800-354-3289			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$141				$202	$160				
USAA[2,4] 1-800-292-8556			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes	$135				$186					$134
WASHINGTON STATE HEALTH CARE AUTHORITY (HCA) BLUE CROSS PREMERA PLANS 1-800-752-6663			**A**	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Age 65 and older	No	Yes					$208					
Under age 65 Medicare disability	No	Yes					$353					

Notes about Washington State HCA plans: These plans are available without a health screening for new residents within 60 days of achieving residency. They are also available without a health screening for Public Employees Benefit Board retirees for the 60 days after retirement if the normal six-month open enrollment period for the plans has expired. A six-month open enrollment may be available for newly eligible Medicare clients with disabilities.

January 2016 Approved Medicare Supplement (Medigap) Plans

Footnotes Explained:
1 = PreX (pre-existing condition) is a health problem you had within the three months before the effective date of your new plan. For this condition, a company cannot exclude benefits for that condition for more than three months after the coverage effective date. If you replace your policy and your previous policy was in effect for at least three months, you have no waiting period for any pre-existing conditions.

2 = These companies have discounts for spouse, electronic funds transfer and/or yearly pay. You may call the phone numbers listed to find out exactly what your discounts may be.

3 = No health screen means the insurance company will not ask you any health questions to decide if they will enroll you in its plan.

4 = You must be a member of an association to buy these plans.

* Medicare Select policies may require you to use specific hospitals, doctors, or other health care providers to get full coverage. Network restrictions must be disclosed to you.

10 Standardized Medicare Supplement (Medigap) plans chart

Effective on or after Jan. 1, 2016

How to read the chart:

- ✓ = policy covers 100% of benefit
- % = policy covers that percentage
- Blank = policy doesn't cover that benefit

Note: The Medicare Supplement policy covers coinsurance only after you've paid the Medicare deductible (unless the policy also covers the deductible).

Basic benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Part A: Hospital coinsurance costs up to an additional 365 days after Medicare benefits end	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Hospice care coinsurance or copay	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B: Coinsurance or copay	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Medicare preventive care Part B coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Parts A & B: Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Additional benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Skilled nursing facility care coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible: $1,288		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible: $166			✓		✓					
Part B excess charges					✓	✓				
Foreign travel emergency (lifetime limit of $50,000)			80%	80%	80%	80%			80%	80%
Out-of-pocket yearly limit**							$4,960	$2,480		

*Plan F offers a high-deductible plan. You pay for Medicare-covered costs up to the deductible amount ($2,180 in 2016) before your plan pays anything.
**After you meet your out-of-pocket yearly limit and Part B deductible, the plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance except up to $20 copays for some office visits and up to $50 copays for emergency room visits (if the hospital admits you, the plan waives your emergency room copays).

Need more help?

There is no yearly open enrollment period for Medicare Supplement (Medigap) plans. You may apply to buy or switch plans at any time.
However, insurers may require you to pass a health questionnaire. If you have questions about who needs to take the questionnaire, call our Insurance Consumer Hotline.
If you want individual help understanding all of your options, call our hotline and ask to speak with a SHIBA counselor in your area.

Insurance Consumer Hotline
1-800-562-6900

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Will Your Medicare Premiums Rise? It depends on your current income and Social Security status.

Your situation now	Will you pay higher premiums?
You pay standard Part B premiums and have them deducted from your Social Security checks	No, because your premiums are deducted from your Social Security check.
You pay higher-income Part B premiums	Yes, even if you receive Social Security benefits
You're enrolled in Part B but pay your premiums directly to Medicare	Yes, because your premiums are not deducted from Social Security benefits
Your Part B premiums are paid by your state	No, because your state will continue to pay your premium
You pay permanent penalties because you signed up late for Part B	Yes, you'll pay more than you do now, because the penalties will be calculated as a percentage of the higher standard premium for 2016
You are not yet enrolled in Part B but will sign up in 2016	Yes, even if you already receive Social Security checks

Revised November 2015

If You Get Extra Help, Make Sure You're Paying the Right Amount

Getting "Extra Help" means Medicare helps pay your Medicare Prescription Drug Plan's (Part D) monthly premium, any yearly deductible, coinsurance, and copayments.

What should my costs be?

If you qualify for full Extra Help, you should pay no more than $2.95 for a generic drug (or brand-name drug treated as a generic) and $7.40 (in 2016) for any other brand-name drug. Some people with higher incomes get partial Extra Help and pay reduced monthly premiums, deductibles, and copayments. If you qualify for partial Extra Help, you'll pay no more than 15% of the costs of drugs on your plan's formulary (drug list) until you reach the out-of-pocket limit.

If you have Medicaid and live in an institution (like a nursing home) or get home- and community-based services, you should pay nothing for your covered drugs.

Most people who qualify for Extra Help also pay nothing for their monthly premium or yearly deductible. If you qualify for full Extra Help and are paying a premium for your Medicare drug plan, you can join another plan and pay no premium in 2016.

You may want to compare the costs, coverage, and customer service ratings of other Medicare drug plans in your area before you switch plans. To compare plans, visit Medicare.gov/find-a-plan. To join a different plan, call 1-800-MEDICARE (1-800-633-4227), or call that plan directly. TTY users should call 1-877-486-2048.

What if I think I'm paying the wrong amount?

Call your Medicare drug plan. Your plan may ask you to provide information to help them check the level of Extra Help you should get. Here are some examples of documents you can send your plan to help prove you qualify for Extra Help:

- A purple notice from Medicare that says you automatically qualify for Extra Help.
- A yellow or green automatic enrollment notice from Medicare.
- An Extra Help "Notice of Award" from Social Security.
- An orange notice from Medicare that says your copayment amount will change next year.
- If you have Supplemental Security Income (SSI), you can use your award letter from Social Security as proof that you have SSI.

You can also give your plan any of the documents below (also called "Best Available Evidence") as proof that you qualify for Extra Help in 2016. Each item listed below must show that you were eligible for Medicaid during a month **after June 2015**.

Proof you have Medicaid & live in an institution or get home- & community-based services	Other proof you have Medicaid
▪ A bill from the institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month ▪ A print-out from your state's Medicaid system showing that you lived in an institution for at least a month and that Medicaid paid for your stay ▪ A document from your state that shows you have Medicaid and are getting home- and community-based services	▪ A copy of your Medicaid card (if you have one) ▪ A copy of a state document that shows you have Medicaid ▪ A print-out from a state electronic enrollment file or from your state's Medicaid systems that shows you have Medicaid ▪ Any other document from your state that shows you have Medicaid

Your plan must accept any of these documents as proof that you qualify for Extra Help. As soon as you've provided any one of these documents, your plan must make sure that you pay no more to fill your prescriptions than the maximum amounts that may be charged for your level of Extra Help.

If you qualify for Extra Help because you have Medicaid, but you don't have or can't find any of these documents, ask your plan for help. Your plan must also contact Medicare so Medicare can get proof that you qualify, if it's available. You can expect your request to take from several days to up to 2 weeks to process, depending on the circumstances. Be sure to tell your plan how many days of medication you have left. Your plan and Medicare will work to process your request before you run out of medication, if possible.

Can I get money back if I've been paying too much?

If you aren't already enrolled in a Medicare drug plan and paid for prescriptions since you qualified for Extra Help, you may be able to get back part of what you paid. Keep your receipts and call your plan or Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 for more information. TTY users should call 711.

Who should I call for help?

If your plan doesn't correct a problem to help you pay the right amount, doesn't respond to your request for help, or takes longer than expected to get back to you, call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users should call 1-877-486-2048. For free help in another language, say "Agent" at any time to talk to a customer service representative.


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Training course evaluation

Statewide Health Insurance Benefits Advisors (SHIBA)

	Strongly Agree	Agree	Disagree	Strongly Disagree
This training was informative and useful.				
The course content held my interest.				
Participation and interaction were encouraged.				
The time allotted for the training was sufficient.				
This training experience will be useful in my work.				
The content was organized and easy to follow.				
Trainer was knowledgeable about the subject matter.				
The trainer was well prepared.				
The training objectives were met.				
The material followed a logical flow.				

1. What did you like most about the training?

2. What aspects of training could be improved?

3. What additional trainings would you like to see in the future?

4. Please share other comments here:

Please tear evaluation off and hand it to your trainer.