ROBERT J. STILLWELL AGENCY, INC.

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Enclosed please find information concerning Medicare and Medicare Gap policies that we spoke about. Medicare is a great program. Medicare must be applied for through the social security office. I have enclosed some information on how to access steps in applying for Medicare.

You have two choices when on Medicare; a Medicare Supplement or a Medicare Advantage plan. The two are quite different, so understanding the advantage and disadvantage of each is very important. I have included an article explaining the differences for your review.

Attached please find our "Turning 65 Medicare Information" package which includes information from enrolling in Medicare, the cost for Part B and D (if any) and the choices available to you. We understand that some people already have a clear understanding of the Medicare program and for others they have no experience with the program and may have many questions. We have been servicing the Medicare Market for over five decades and are here to answer your questions and help!

The great news for someone just enrolling in Medicare is that you are guaranteed issue and if you've had credible coverage for at least six months, there are no pre existing conditions.

Along with a Medicare Supplement I would recommend a Part D plan to cover your prescriptions. Part D plans need to be evaluated based on your individual medications so that the formulary can be researched to assure that prescriptions are covered. Each company and plan has its own formulary (list of covered prescriptions). Please complete the enclosed worksheet so I can review and search for the plan that best fits your needs. Along with Part D information please find a scope of appointment that requires your signature so I can further discuss the plan with you.

Medicare advantage plans are much different than Medicare Supplement Plans. They are similar to underage HMO and PPO plans which include networks of providers, co pays, out of pocket maximums and some include additional benefits such as prescription drug plans, dental, vision, hearing and over the counter benefits for routine health items. These plans can provide a $0 planned premium or much lower premium than a Medicare Supplement but are much more complex and need to be selected based on your individual needs. If you would like to consider a Medicare Advantage Plan we have several outstanding plans in your area.

Please take the time to review the enclosed information. I will reach out to you in a week or so to answer any questions you may have, but in the meantime please do not hesitate to call me directly.

I thank you for the opportunity to provide you this information. I would be honored to help.

Respectfully,

Robert J Stillwell Agency

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For more detailed info you may visit medicare.gov.

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Robert J. Stillwell became a self-employed entrepreneur over 50 years ago when he started an independent life and health insurance agency. His belief in professional management, along with skilled and courteous customer service, has insured the success of the Agency.

Throughout the states of Pennsylvania, Ohio, New York, Iowa, Wyoming, New Jersey, Alaska, Florida and Delaware our Life and Health Agency reports in an excess of 15,000 policy holders. This is primarily in the senior health market. The agency is one of the leading senior health producers in the state. The needs of our elderly have become more critical as the 60+ age group increases at a rapid rate. The Stillwell Agency has been servicing these needs for over five decades. We have Medicare Supplement, Medicare Advantage, Life, Home Health Care, Hospital Indemnity and Cancer plans to service the needs of our policyholders.

Our current sales team averages 15 years association with the Agency. Commitment to the needs of the client has developed a firm client/agent relationship. This Agency provides full service support to maintain above-average client retention. We believe that an agent should diligently service the client's needs and our support staff will assist with all paperwork.

Philosophies, which we have implemented and feel strongly contribute to the building of an agency, are as follows:

Integrity First and foremost we are an honest company, believing that if we work in the clients' best interest; we not only fulfill our obligations, but build a rapport and positive relationship with the client.

Stability Personnel is a key facet of any organization and we feel consistency and stability of personnel is as important to our organization as are our clients. Our Customer Service Representatives are courteous and knowledgeable. They are trained for specific products and companies so they are well versed.

Underwriting Strict underwriting guidelines are adhered to in our office before the applications are submitted to any carrier. We carefully examine all applications to insure an accurate and prompt issue.

Persistency To maintain a book of business, we believe the key is service. Servicing our clients promptly and consistently is a high priority. We recognize that when you have a question or claim is when you need our assistance most.

SERVICE SUPPORT

Full-time Customer Service Representatives are available to assist our Agents and Clients with any situation. When an application is submitted to a carrier, our Customer Service Representatives will track the application through new business to policy issue. They will also attempt to expedite any APS request.

Complete client files are maintained to insure accurate information for:

- Benefits
- Claims
- Paid-to Dates

We are available to answer any questions or assist with the claims process. We answer our phones personally. You will always be greeted by a friendly voice and directed to whom you need to speak with.

Clients may call our Customer Service Representatives directly with any questions they may have. Your assigned a designated customer service representative so that you speak with the same person on a consistent basis. That person is well versed with your policy and company so she is able to assist you with any questions you may have.

Clients may also send their claims to the Agency for submission to the proper carrier.

WE ARE HAPPY TO OFFER COURTEOUS, PROMPT SERVICE TO OUR AGENTS AND CLIENTS

2023 MEDICARE PART A

Part A is Hospital Insurance and covers costs associated with confinement in a hospital or skilled nursing facility

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When you are hospitalized for:	Medicare Covers	You Pay
1 – 60 days	Most confinement costs after the required Medicare Deductible	**$1,600** Deductible
61 – 90 days	All eligible expenses after the patient pays a per day co-payment	**$400** A DAY COPAYMENT as much as **$12,000**
91 – 150 days	All eligible expenses after patient pays a per day co-payment. (These are Lifetime Reserve Days which may never be used again.)	**$800** A DAY COPAYMENT as much as **$48,000**
151 days or more	NOTHING	**YOU PAY ALL COSTS**
SKILLED NURSING CONFINEMENT: When you are hospitalized for at least three (3) days and enter a Medicare-approved skilled nursing facility within 30 days after hospital discharge and are receiving skilled nursing care.	All eligible expenses for the first 20 days; then all eligible expenses for days 21 – 100 after patient pays a per day co-payment.	After 20 days **$200.00** A DAY COPAYMENT as much as **$16,000**

2023 MEDICARE PART B

Medicare Part B premium is $164.90

Part B is Medical Insurance

and covers physician services, outpatient care, tests and supplies

On expenses incurred for:	**Medicare Covers**	**You pay $226 Annual Deductible PLUS**
Medical Expenses Physicians services for in-patient, outpatient medical/surgical services; physical/speech therapy, diagnostic tests	80% of approved amount	20% of approved amount
Clinical Laboratory Services Blood tests, urinalysis	Generally 100% of approved amount	Nothing for services
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical supplies and other services.	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 Hospital services for the diagnosis or treatment of an illness or injury.	Medicare payment of hospital, based on outpatient procedure payment rates	Co-insurance based on outpatient payment rates
Blood	After first three (3) pints of blood, 80% of approved amount	First three (3) pints plus 20% of approved amount for additional pints

On all Medicare covered expenses, a doctor or other health care provider may agree to accept Medicare "assignment." This means the patient will not be required to pay any expense in excess of Medicare's "approved" charge. The patient pays only 20% of the "approved" charge not paid by Medicare.

Physicians who do not accept assignment of Medicare claim are limited as to the amount they can charge for covered services. In 2008, the most a physician can charge for services covered by Medicare is 115% of the approved amount for non-participating physicians.

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Overview of Available Plans

Medicare Supplement Plans A, B, C, F, G, K, L and N are currently being offered by UnitedHealthcare Insurance Company.

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A, B and D or G. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔ means 100% of this benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2023[2]					$6940[2]	$3470[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of- pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Plan Benefit Tables: Plan G

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan G Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,600	$1,600 (Part A deductible	$0
	Days 61-90	All but $400 per day	$400 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $800 per day	$800 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $200 per day	Up to $200 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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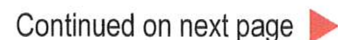

Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan G (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $226 of Medicare-approved amounts[3]	$0	$0	$226 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $226 of Medicare-approved amounts[3]	$0	$0	$226 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment Medicare-approved services	First $226 of Medicare-approved amounts[3]	$0	$0	$226 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits not covered by Medicare				
Service		**Medicare Pays**	**Plan G Pays**	**You Pay**
Foreign Travel NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the 60 days of each trip outside the USA.	First $250 of each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 Once you have been billed $226 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period[1]

Service		Medicare Pays	Plan N Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1,600	$1,600 (Part A deductible	$0
	Days 61-90	All but $400 per day	$400 per day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $800 per day	$800 per day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $200 per day	Up to $200 per day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	$0

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Notes

1 A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year				
Service		**Medicare Pays**	**Plan N Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL, AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $226 of Medicare-approved amounts[3]	$0	$0	$226 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs
Blood	First 3 pints	$0	All costs	$0
	Next $226 of Medicare-approved amounts[3]	$0	$0	$226 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B				
Service		**Medicare Pays**	**Plan N Pays**	**You Pay**
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0

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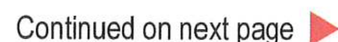

Notes

3 Once you have been billed $226 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Service		Medicare Pays	Plan N Pays	You Pay
Parts A and B, continued				
Durable medical equipment Medicare-approved services	First $226 of Medicare-approved amounts[3]	$0	$0	$226 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits not covered by Medicare				
Foreign Travel NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the 60 days of each trip outside the USA.	First $250 of each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Notes

3 Once you have been billed $226 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

MEDICARE RIGHTS CENTER

Getting Medicare right

Original Medicare with a Medigap vs. Medicare Advantage

If you have **Original Medicare**, the traditional health insurance program run by the federal government, it pays for most of your health care. However, it doesn't pay for everything. The out-of-pocket costs can get expensive for people who need a lot of health care.

There are two ways you may be able to lower your costs. One way is to keep Original Medicare and buy supplemental insurance to help pay your out-of-pocket costs. **Medigap plans** are supplemental insurance you can buy. Medigaps work only with Original Medicare, not with Medicare Advantage Plans. Private insurance companies sell Medigaps.

Another way you may be able to save money is to get your Medicare benefits through a **Medicare Advantage Plan** instead of Original Medicare. Medicare Advantage Plans, or Medicare private health plans, are also sold by insurance companies. They're usually HMOs or PPOs. Medicare Advantage Plans must cover the same benefits as Original Medicare, but your costs may be different. When you're in a Medicare Advantage Plan, you pay more for some types of health care and you pay less for other types of care.

If you have insurance from a job, **never join a Medicare Advantage Plan without checking with your employer insurance first.** Find out how joining a Medicare Advantage Plan will affect your benefits. This is important whether you're retired or still working.

If you're choosing between Original Medicare with a Medigap or a Medicare Advantage Plan, look at your needs and what you can afford. Here are some facts about both to help you decide.

Medigaps

- Let you keep Original Medicare. You can go to any doctor or hospital in the country that accepts Medicare. The Medigap will help cover your Medicare out-of-pocket costs.
- Are standardized by law. Plans sold between July 31, 1992 and May 31, 2010 cover a certain set of benefits. Plans sold on or after June 1, 2010 cover a slightly different set of benefits.
- Are labeled by letter. All Medigaps of the same letter cover the same benefits no matter which insurance company sells them.
- Are sold by different companies. These companies can charge different prices for the same coverage. It pays to shop around. Medigap prices vary based on where you live and your age.
- Only let you enroll at certain times. Each state has its own rules about when you can buy a Medigap. A few states let you to enroll any time.

Medicare Advantage Plans (HMOs or PPOs)

- Must cover all benefits Original Medicare covers. They may also cover extra benefits that Original Medicare doesn't cover, such dental or vision care.
- Have different rules and costs than Original Medicare. May restrict when and how you get care.
- Have yearly out-of-pocket spending limits. These limits can be high but protect you if you need a lot of care.
- May have networks of doctors and hospitals you must use if you want to pay the lowest price.
- Only let you enroll in or switch plans at certain times. Once you buy a Medicare Advantage Plan, you must usually stay in that plan until the next enrollment period.

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Medigaps vs. Medicare Advantage Plans

Benefit	Medigaps	Medicare Advantage Plans
Lowers costs for services?	**Yes.** Pays part or all of your costs when you go to the doctor or hospital.	**Depends.** Your costs for health care (copayments or coinsurances) may be more or less than what you pay in Original Medicare. You may pay the full cost if you don't follow your Medicare Advantage Plan's rules.
Protects you from unexpected costs?	**Yes.** Pays your full hospital coinsurance and pays for 365 extra days in the hospital beyond what Original Medicare covers.	**No.** Some types of care can be more expensive than under Original Medicare. You can't buy supplemental insurance to pay your out-of-pocket costs. Medicare Advantage Plans must have an annual out-of-pocket limit. These limits can be high but will protect you if you need expensive health care.
Covers extra services?	**Very little.** Medigaps usually don't cover anything Original Medicare doesn't cover. However, some do extend Medicare coverage, for example by covering emergency care outside of the United States.	**Maybe.** May cover some services Original Medicare doesn't cover. Some cover routine eye, hearing and dental care. Those benefits may be limited, so check carefully.
Lets you go to doctors and hospitals of your choice?	**Yes.** You can go to any doctor or hospital in America that accepts Medicare. (Unless you have a Medicare SELECT plan. Medicare SELECT is a type of Medigap plan that only pays for care you get in its network.)	**No.** Most have a network of doctors and hospitals that you must use for the plan to cover your care. You may pay much more if you go out of the plan's network.
Requires referral to see a specialist?	**No.** You don't need a referral.	**Maybe.** You often need to get a referral from your primary care physician if you want to see a specialist.
Has high monthly fees?	**Yes.** The premium, which is the monthly fee you pay to be in the plan, can be several hundred dollars per month. Premiums vary based on where you live and which plan you want. You also pay the Original Medicare premium each month. If you want drug coverage, you can buy a separate Medicare drug plan. Medigaps don't cover drugs.	**Generally, no.** Many plans don't charge more than what you pay for Original Medicare. But some plans do. Plans that include drug coverage often cost more.
Limits when you can enroll?	**Depends.** In many states, you can only enroll at certain times of the year and if you are age 65 or older. Check with your state insurance department. New York has **Continuous Open Enrollment** for Medigaps. People in New York with Medicare can buy a Medigap at any time.	**Yes.** You can usually only enroll in a Medicare Advantage Plan or switch plans during the Fall Open Enrollment period from Oct.15 through Dec. 7.

Medicare Enrollment: How and When to Enroll in Medicare

You have several options when the time comes for you to enroll in Medicare. For some people, Medicare enrollment is automatic, while for others, it may depend on when and how they become eligible.

How to enroll in Medicare

You can enroll in Medicare Part A and/or Medicare Part B in the following ways:

- Online at www.SocialSecurity.gov.
- By calling Social Security at 1-800-772-1213 (TTY users 1-800-325-0778), Monday through Friday, from 7AM to 7PM.
- In-person at your local Social Security office.

If you worked at a railroad, enroll in Medicare by contacting the Railroad Retirement Board (RRB) at 1-877-772-5772 (TTY users 1-312-751-4701). You can call Monday through Friday, 9AM to 3:30PM, to speak to an RRB representative.

When to enroll in Medicare

There are a few situations where Medicare enrollment may occur automatically:

If you are receiving retirement benefits:
If you're already collecting Railroad Retirement Board or Social Security retirement benefits when you turn 65, you will automatically be enrolled Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) if you sign up for Medicare Part B at the time you sign up for retirement benefits.

If you live outside of the 50 United States or D.C. (for example, if you live in Puerto Rico), you will automatically be enrolled in Medicare Part A, but will need to manually enroll in Medicare Part B.

If you are receiving disability benefits:
If you are under 65 and receiving certain disability benefits from Social Security or the Railroad Retirement Board, you will be automatically enrolled in Original Medicare, Part A

and Part B, after 24 months of disability benefits. The exception to this is if you have end-stage renal disease (ESRD). If you have ESRD and had a kidney transplant or need regular kidney dialysis, you can apply for Medicare. If you have amyotrophic lateral sclerosis (also known as ALS or Lou Gehrig's disease), you will automatically be enrolled in Original Medicare in the same month that your disability benefits start.

If you don't want Medicare Part B:
If you're automatically enrolled in Medicare Part B, but do not wish to keep it you have a few options to drop the coverage. If your Medicare coverage hasn't started yet and you were sent a red, white, and blue Medicare card, you can follow the instructions that come with your card and send the card back. If you keep the Medicare card, you keep Part B and will need to pay Part B premiums. If you signed up for Medicare through Social Security, then you will need to contact them to drop Part B coverage. If your Medicare coverage has started and you want to drop Part B, contact Social Security for instructions on how to submit a signed request. Your coverage will end the first day of the month after Social Security gets your request.

If you have health coverage through current employment (either through your work or your spouse's employer), you may decide to delay Medicare Part B enrollment. You should speak with your employer's health benefits administrator so that you understand how your current coverage works with Medicare and what the consequences would be if you drop Medicare Part B.

Medicare Part B late-enrollment penalty:
If you do not sign up for Medicare Part B when you are first eligible, you may need to pay a late enrollment penalty for as long as you have Medicare. Your monthly Part B premium could be 10% higher for every full 12-month period that you were eligible for Part B, but didn't take it. This higher premium could be in effect for as long as you are enrolled in Medicare. For those who are not automatically enrolled, there are various Medicare enrollment periods during which you can apply for Medicare. Be aware that, with certain exceptions, there are late-enrollment penalties for not signing up for Medicare when you are first eligible.

One exception is if you have health coverage through an employer health plan or through your spouse's employer plan, you can delay Medicare Part B enrollment without paying a late-enrollment penalty. This health coverage must be based on current employment, meaning that COBRA or retiree benefits aren't considered current employer health coverage.

Medicare Initial Enrollment Period

For most people, enrolling in Medicare Part A is automatic. However, there are several instances where you may have to manually enroll in Medicare Part A and/or Part B during your Initial Enrollment Period (IEP), the seven-month period that begins three months before you turn 65, includes the month of your 65th birthday, and ends three months later.

Some situations where you would enroll in Medicare during your initial enrollment include:

If you aren't receiving retirement benefits:
If you are not yet receiving retirement benefits and are close to turning 65, you can sign up for Medicare Part A and/or Part B during your IEP. If you decide to delay your Social Security retirement benefits or Railroad Retirement Benefits (RRB) beyond age 65, there is an option to enroll in just Medicare and apply for retirement benefits at a later time.

If you do not qualify for retirement benefits:
If you are not eligible for retirement benefits from Social Security or the RRB, you will not be automatically enrolled into Original Medicare. However, you can still sign up for Medicare Part A and/or Part B during your IEP. You may not be able to get premium-free Medicare Part A, and the cost of your monthly Part A premium will depend on how long you worked and paid Medicare taxes. You will still have to pay a Medicare Part B premium.

Medicare General Enrollment Period

If you did not enroll during the IEP when you were first eligible, you can enroll during the General Enrollment Period. The general enrollment period for Original Medicare is from January 1 through March 31 of each year. Keep in mind that you may have to pay a late enrollment penalty for Medicare Part A and/or Part B if you did not sign up when you were first eligible.

Medicare Special Enrollment Period

You may choose not to enroll in Medicare Part B when you are first eligible because you are already covered by group medical insurance through an employer or union. If you lose your group insurance, or if you decide you want to switch from your group coverage to Medicare, you can sign up at any time that you are still covered by the group plan or during a Special Enrollment Period(SEP).

Your eight-month special enrollment period begins either the month that your employment ends or when your group health coverage ends, whichever occurs first. If you enroll during an SEP, you generally do not have to pay a late enrollment penalty.

The Special Enrollment Period does not apply if you're eligible for Medicare because you have ESRD. Please also keep in mind that COBRA and retiree health coverage are not considered current employer coverage and would not qualify you for a special enrollment period.

Medicare Advantage plan enrollment

Medicare Advantage, also known as Medicare Part C, is another way to receive Original Medicare benefits and is offered through private insurance companies. At minimum, all Medicare Advantage plans must offer the same Medicare Part A and Part B benefits as Original Medicare. Some Medicare Advantage plans also include additional benefits, such as prescription drug coverage. You must have Original Medicare, Part A and B, to enroll in a Medicare Advantage plan through a private insurer.

You can enroll in a Medicare Advantage plan during two enrollment periods, the Initial Coverage Election Period and Annual Election Period.

Medicare Advantage plan Initial Coverage Election Period:
Most beneficiaries are first eligible to enroll in a Medicare Advantage plan during the Initial Coverage Election Period. Unless you delay Medicare Part B enrollment, this enrollment period takes place at the same time as your Initial Enrollment Period (IEP), starting three months before you have both Medicare Part A and Medicare Part B and ending on whichever of the following dates falls later:

- The last day of the month before you have both Medicare Part A and Part B, or
- The last day of your Medicare Part B Initial Enrollment Period.

If you're under 65 and eligible for Medicare due to disability, your IEP will vary depending on when your disability benefits started.

Medicare Advantage plan Annual Election Period:
You can also add, drop, or change your Medicare Advantage plan during the Annual Election Period, which occurs from October 15 to December 7 of every year. During this period, you may:

- Switch from Original Medicare to a Medicare Advantage plan, and vice versa.
- Switch from one Medicare Advantage plan to a different one.
- Switch from a Medicare Advantage plan without prescription drug coverage to a Medicare Advantage plan that covers prescription drugs, and vice versa.

Medicare Advantage Disenrollment Period:
You'll have the opportunity to disenroll from your Medicare Advantage plan and return to Original Medicare during the Medicare Advantage Disenrollment Period, which runs from

January 1 to February 14. You cannot use this period to switch Medicare Advantage plans or make other changes. However, if you decide to drop your Medicare Advantage plan, you can also use this period to join a stand-alone Medicare prescription drug plan, since Original Medicare doesn't include prescription drug coverage.

Outside of the Annual Election Period and the Medicare Advantage Disenrollment Period, you cannot make changes to your Medicare Advantage plan unless you qualify for a Special Election Period.

Medicare prescription drug coverage

Medicare prescription drug coverage is optional and does not occur automatically. You can receive coverage for prescription drugs by either signing up for a stand-alone Medicare prescription drug plan or a Medicare Advantage plan that includes drug coverage, also known as a Medicare Advantage Prescription Drug plan. Medicare prescription drug plans and Medicare Advantage plans are available through private insurers. Please note that you cannot have both a stand-alone Medicare prescription drug plan and a Medicare Advantage plan that includes drug coverage.

Initial Enrollment Period for Medicare Part D:
You can enroll in a stand-alone Medicare prescription drug plan during your Initial Enrollment Period for Part D. You are eligible for drug coverage if:

- You live in a service area covered by the health plan, and
- You have Medicare Part A AND/OR Medicare Part B.

Generally, your Initial Enrollment Period for Part D will occur at the same time as your Initial Enrollment Period for Medicare Part B (the seven-month period that starts three months before your eligibility for Part B, includes the month you are eligible, and ends three months later).

Once you are eligible for Medicare Part D, you must either enroll in a Medicare prescription drug plan, Medicare Advantage Prescription Drug plan, or have creditable prescription drug coverage(that is, drug coverage that is expected to pay at least as much as standard Medicare prescription drug coverage). Some people may choose to delay Medicare Part D enrollment if they already have creditable drug coverage through an employer group plan.

However, if you do not sign up for prescription drug coverage when you are first eligible for Part D, you may have to pay a late-enrollment penalty for signing up later if you go without creditable prescription drug coverage for 63 or more consecutive days.

Medicare Part D Annual Election Period:
If you did not enroll in drug coverage during IEP, you can sign up for prescription drug coverage during the Annual Election Period that runs every year from October 15 to December 7.

During AEP, you can:

- Sign up for a Medicare prescription drug plan.
- Drop a Medicare prescription drug plan.
- Join a Medicare Advantage plan that includes prescription drug coverage.
- Switch from a Medicare Advantage plan that doesn't include drug coverage to a Medicare Advantage plan that does (and vice versa).

Outside of the Part D Initial Enrollment Period and the Annual Election Period, the only time you can make changes to prescription drug coverage without a qualifying Special Election Period is during the Medicare Advantage Disenrollment Period (MADP)–but only if you are dropping Medicare Advantage coverage and switching back to Original Medicare. The Medicare Advantage Disenrollment Period runs from January 1 to February 14.

Medicare Part A and Part B do not include prescription drug coverage, and if you switch back to Original Medicare during the Medicare Advantage Disenrollment Period, you will have until February 14 to join a stand-alone Medicare prescription drug plan.

Medicare Supplement insurance plans enrollment

Medicare Supplement insurance plans (or Medigap) are voluntary, additional coverage that helps fills the gaps in coverage for Original Medicare. The best time to enroll in a Medicare Supplement insurance plan is during your individual Medigap Open Enrollment Period, which is the six-month period that begins on the first day of the month you turn 65 and have Medicare Part B. If you decide to delay your enrollment in Medicare Part B for certain reasons such as having health coverage based on current employment, your Medigap Open Enrollment Period will not begin until you sign up for Part B.

During your Medigap Open Enrollment Period, you have a "guaranteed-issue right" to buy any Medigap plan sold in your state. This means that insurance companies cannot reject your application for a Medicare Supplement insurance plan based on pre-existing health conditions or disabilities. They also cannot charge you a higher premium based on your health status. Outside of this open enrollment period, you may not be able to join any Medigap plan you want, and insurers can require you to undergo medical underwriting. You may have to pay more if you have health problems or disabilities.

Understanding drug payment stages

Up to
$505

Deductible stage

During this stage, if your plan has a deductible, you'll pay the plan's negotiated drug cost up to the deductible limit.

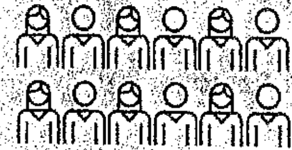
Once you reach the deductible limit, you'll pay a copayment or coinsurance in the initial coverage stage.

Up to
$4,660

Initial coverage stage

During this stage, the plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription you fill until your total drug costs reach $4,660.

Once you reach $4,660, you'll enter the coverage gap stage or "donut hole."



Most people will remain in this stage.

Up to
$7,400

Coverage gap stage

(Also known as the donut hole.)

During this stage, you'll pay 25% of the cost for generics and brands. Our SilverScript Plus plan offers additional coverage in the gap for Tier 1 and Tier 2 drugs. This stage continues until your yearly out-of-pocket drug costs reach $7,400.

Once your yearly out-of-pocket costs reach $7,400, you'll move to catastrophic coverage.

Some people will move into this stage.

Through the end of the year

Catastrophic coverage stage

In this stage, you'll pay either a copayment or coinsurance amount for each prescription you fill.

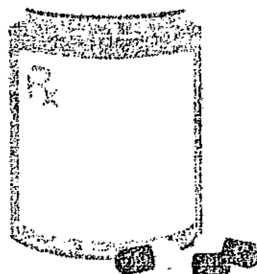
Few people will reach this stage.

What does your Medicare Part D plan cover?

The prescription drugs that your Medicare Part D plan cover will vary from plan to plan. That is why you will almost always be provided with a list of formulary drugs and their amount that is covered by your plan.

It's vital that you check with each Part D plan, as one plan may cover more than another plan. Some plans may not cover the prescriptions you need at all.

In addition to covering prescription drugs based on multiple tiers, many Medicare Part D prescription plans offer a separate tier for injectable drugs, like insulin. The cost sharing options for injectable tiers tend to be higher. When the time comes to use your coverage, you may find that your plan pays for a portion of your prescription costs, while you need to pay for a certain portion of the rest. The amount of money that you are required to pay for your plans coinsurance or copayment will also vary from plan to plan. This makes it important to understand what your plan covers after the set initial deductible amount is fulfilled.



Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. Please check what you want to discuss with the Licensed Sales Representative.

Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):

- ☐ Medicare Advantage Plans (Part C) and Cost Plans
- ☐ Stand-alone Medicare Prescription Drug Plan (Part D)
- ☐ Medicare Supplement (Medigap) Plan
- ☐ Dental-Vision-Hearing Products
- ☐ Hospital Indemnity Products

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do not work directly for the federal government.

Signing this form does not affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: ______________________ Signature Date: ______________________

If you are the authorized representative, please sign above and print clearly and legibly below:

Representative's Name: ______________________ Your Relationship to the Beneficiary: ______________________

To be completed by the Licensed Sales Representative (print clearly and legibly):

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the Licensed Sales Representative will represent during the meeting	
Licensed Sales Representative Signature		

Scope of Appointment documentation is subject to CMS record retention requirements

10/01/17

v.1.1

Product Descriptions

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Point-of-Service (HMO-POS) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Other Health-Related Products

Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.

Hospital Indemnity Products— Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray co-pays/co-insurance. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products— Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.

Please complete so I can review your prescriptions and place you in the plan that best fits your individual needs.

Personal Worksheet

Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Current Medication	Actual Dosage	Tier	Co – Pay	Co – Insurance

Most Suitable Part D Plan:

____

Annual Deductible:

____

Good Rx

Go to: http://www.goodrx.com/

Then type in the name of your prescription and the town or zip code, then click on the button "find the lowest price".

Then a list of pharmacies and their prices will come up in price order from lowest to highest.

On the left-hand side of this page you can adjust the radius, dosage, brand vs, generic, amount, and pharmacy type. Furthermore, you can also add your prescription insurance plan to find out what your co-pay would be at each pharmacy.

It will also show if there are coupons for this medicine, with a link so you can print out the coupon.

You can also join GoodRx to receive notifications if your prescriptions is lowered in cost at any pharmacy.

Common Questions:

Can I use the coupon with my health insurance?

This coupon price may be lower than your health insurance co-pay, but it cannot be used to lower your co-pay. Ask your pharmacist to help you find the best possible price.

This website helps locate pharmacies with the lowest costs for specific prescriptions. It sometimes also provides manufactures coupons to keep costs low.

IRMAA for 2023

Full Part B Coverage

Beneficiaries who file individual tax returns with modified adjusted gross income:	Beneficiaries who file joint tax returns with modified adjusted gross income:	Income-Related Monthly Adjustment Amount	Total Monthly Premium Amount
Less than or equal to $97,000	Less than or equal to $194,000	$0.00	$164.90
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	$65.90	$230.80
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	$164.80	$329.70
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	$263.70	$428.60
Greater than $183,000 and less than $500,000	Greater than $366,000 and less than $750,000	$362.60	$527.50
Greater than or equal to $500,000	Greater than or equal to $750,000	$395.60	$560.50

Part D

Beneficiaries who file individual tax returns with modified adjusted gross income:	Beneficiaries who file joint tax returns with modified adjusted gross income:	Income-related monthly adjustment amount
Less than or equal to $97,000	Less than or equal to $194,000	$0.00
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	12.20
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	31.50
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	50.70
Greater than $183,000 and less than $500,000	Greater than $366,000 and less than $750,000	70.00
Greater than or equal to $500,000	Greater than or equal to $750,000	76.40