

Plan recap

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

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

Plan Information

Here are some details about your new plan.

My new plan is a: Medicare Advantage plan Medicare Advantage Special Needs plan
 Medicare Supplement Insurance (Medigap) plan Medicare Part D plan

The name of my new plan is: _____

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

My plan type: Requires referrals Does not require referrals

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

Does not include a medical deductible

My plan will provide: All Medicare health coverage All Medicare prescription drug coverage

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

Proposed effective date: - -

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

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

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

Circle the correct answer: I should / should not have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time.

Premium Information

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

My plan has a \$ _____ monthly premium that I must pay to stay in this plan. If I qualify for Extra Help, my premium may be less.* In addition, I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me. If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.

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

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



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

Network Information

Understanding your network is important.

With my plan, I need to get my care and services from network providers. I may have to pay the full cost for any care I get from out-of-network providers. Emergency care, urgent care, and out-of-area dialysis is covered wherever I need it. **Yes** **No**

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

Provider Name	Provider Type (PCP/Specialist/Hospital)	Network (Yes/No)	Referral (Yes/No)
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Prescription Drug Coverage

Know how prescription drugs are covered on your plan.

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

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

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

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

Medication	Tier Level ¹	Has Limits ² (Yes/No)	Deductible (Yes/No)
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¹ My actual out of pocket costs may vary based on: the drug stage I am in, my drug tier level, the pharmacy I use (retail/mail-order), and if I have Extra Help, and if my plan is participating in the Part D Senior Savings Model. ² For medications that have limitations, I may need to contact the plan before I can fill my prescription. I can discuss alternatives by calling customer service to learn what other drugs might be on the drug list and by talking with my doctor or pharmacist.

I have **opted / not opted** to access some plan documents electronically. I can update or change this anytime. I have **provided / not provided** my email address as another way for the plan to contact me with important information. I can update or change this anytime.



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