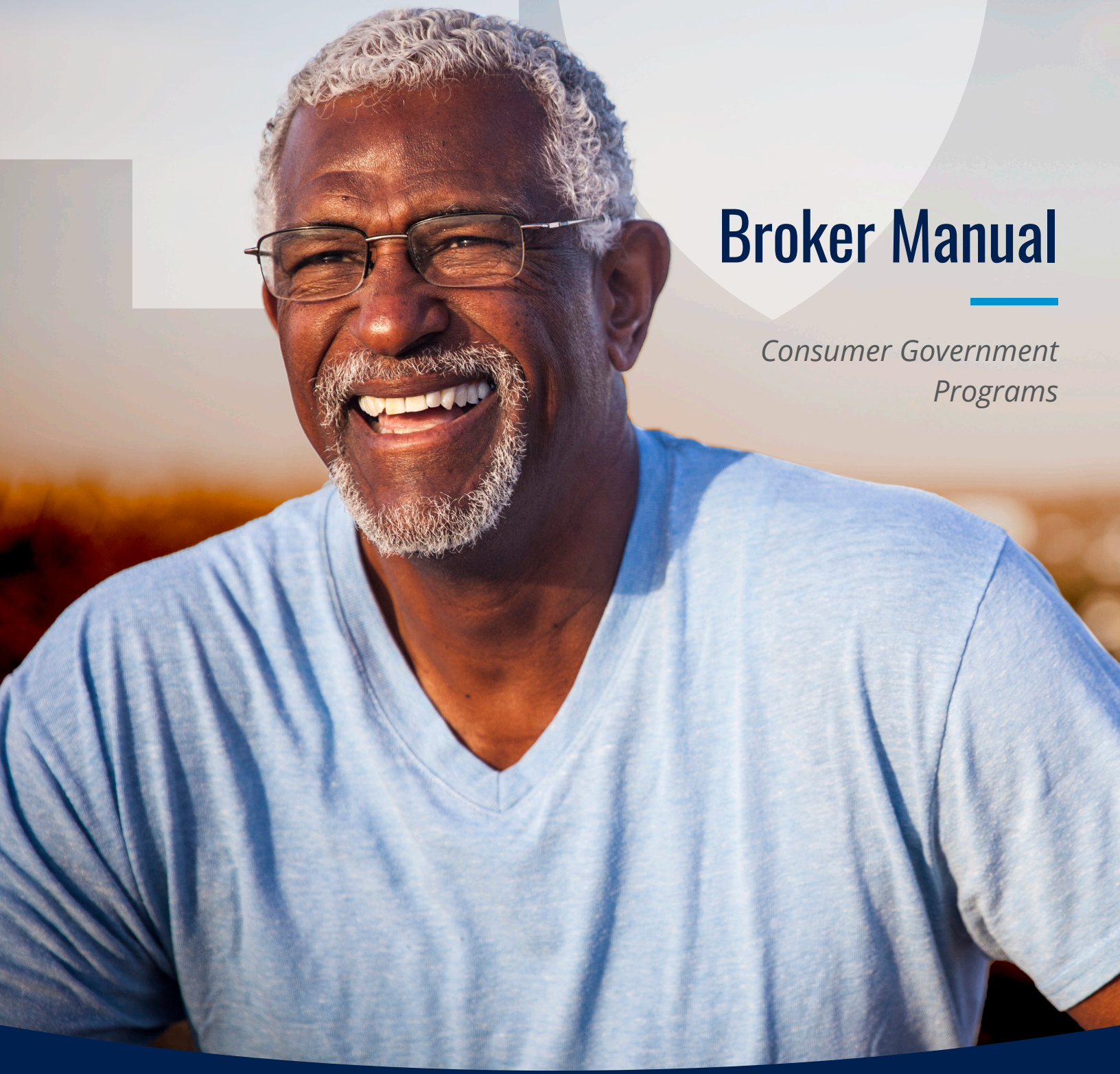
CareFirst MedPlus



Broker Manual

Consumer Government Programs

CAREFIRST MEDPLUS MEDICARE SUPPLEMENT
2022 BROKER MANUAL

Contents

Welcome Agencies and Sub-Agents

We are pleased to present our CareFirst Consumer Government Programs MedPlus Broker Manual. This document was created for informational purposes only and is not intended to provide legal and/or accounting advice and should not be relied upon as such.

Agency: is a partnership or corporation operating in accordance with the Annotated Code of Maryland or equivalent statute in the appropriate state or legal jurisdiction in which it holds a license to sell health insurance and related products and solicits through other Brokers and/or Agents who function as Producing Agents of the Brokerage/ Agency and handles applications for and renewals of insurance contracts, and for compensation, solicits, procures, negotiates, or makes insurance contracts, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations, or the renewal or continuance of these insurance contract for persons issuing the insurance contracts, and who has been appointed by Insurer in accordance with the Annotated Code of Maryland or equivalent statute in the appropriate state or legal jurisdiction in which it holds a license to sell health insurance and related products.

Sub-Agent: means a person that, for compensation, solicits, procures, negotiates, or makes insurance contracts, including contracts for nonprofit health service plans, dental plan organizations, and health maintenance organizations, or the renewal or continuance of these insurance contracts for persons issuing the insurance contracts, who has been contracted by Insurer under the terms of a CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services, Inc. Broker/Agent Agreement, and who has been appointed by Insurer in accordance with the Annotated Code of Maryland or equivalent statute in the appropriate state or legal jurisdiction in which agent holds a license to sell health insurance and related products.

Broker Contact List

Inquiries	
For general inquiries, the Sub-Agent must provide agent tax ID and verify the member's information, which includes the caller's and member's name plus 3 items from the below: 1. Member's SID (Subscriber ID) 2. Member's DOB 3. Member's Address including Apt #, City and State 4. Member's Zip Code 5. Member's Social Security Number 6. Member's Telephone Number **NOTE:** A HIPAA Member Authorization form is required for a CareFirst Representative to discuss detailed member claims or eligibility issues with individuals other than the member. The member should be referred to the Member Customer Service area for assistance in completing and submitting this form.	
Medicare MedPlus Inquiry type: Application Status, Benefits, Claims, Enrollment/ Billing and General Questions: **All Agencies and Sub-Agents contact:**	■ Sub-Agents may submit inquiries directly to the status line by email at BrokerServicesTeam@CareFirst.com. ■ Sub-Agents may make up to 10 inquiries per call. ■ Sub-Agents with inquiries above the allotted 10 may call back or submit an electronic inquiry through their Agency. ■ Sub-Agents should contact their Agency for assigned dedicated phone number.

Applications and Forms	
Find general forms and marketing materials:	Available on the Broker Portal
Mail or fax: ■ Completed and signed applications ■ Change forms ■ Cancellation requests (Note: this form cancels the entire policy and should not be used to remove individuals from the plan) ■ Letters of Creditable Coverage and ■ Any enrollment correspondence for members or prospective members only on a Consumer/Direct Bill policy **NOTE TO SUB-AGENTS:** Applications and correspondence should be submitted to your dedicated Agency so that they can appropriately track your cases.	Mailroom Administrator PO Box 14651 Lexington, KY 40512 Fax: 800-305-1351 or 410-505-2901 (The application should always be faxed first followed by the Replacement of Coverage Form (if applicable) second and the Broker Acknowledgement Form last. All documents must be faxed separately.)
Attending Physician Statement (APS) forms:	CareFirst BlueCross BlueShield Central Medical Review Mailstop Code DC09-15 840 First Street, NE Washington, DC 20065 or Fax: 301-470-5799

Broker Contact List

Premium Payments

- Members may access *My Account* at www.carefirst.com to make on-line payments and set up recurring payments.
- Members may call Member Services at 800-722-2235.
- Pay by cash through CheckFreePay at select Walmart locations:
  Go to www.checkfreepay.com/info/payinperson to find a participating location.
- Members may mail a check or money order (made out to CareFirst BlueCross BlueShield) and invoice stub to:

  Payment Administrator
  PO Box 70250
  Philadelphia, PA 19176-0250

IMPORTANT: If an invoice is not available, member must include their name, ID number and group number on the check/money order. To ensure timely payments, member should mail the payment several days in advance.

Commission Inquiries

Medicare MedPlus	Sub-Agents must contact their dedicated Agency.

Broker Contracting & Compliance, Broker of Record (BOR), Contracts & Appointments

Contracting & Appointment paperwork and documentation:	Sub-Agents must contact their dedicated Agency.
General inquiries:	Broker Contracting & Compliance 10455 Mill Run Circle-OM2-415 Owings Mills, Maryland 21117 Email: BCC@carefirst.com Fax: 410-505-2933

CareFirst MedPlus

Medicare Supplement Open Enrollment

The best time for a beneficiary to sign up is during his/her Medicare Supplement Open Enrollment Period. The CareFirst MedPlus Open Enrollment Period* lasts for 6 months and begins the 1st day of the month when an individual is both:

- 65 years old or older and
- Enrolled in Medicare Part B

NOTE: Individuals born on the first day of any month are considered to have turned 65 on the first of the *previous* month. For example, if an individual's birthday is February 1st, he or she is deemed to have turned 65 on January 1st.

*For an individual under age 65 and disabled, the Open Enrollment Period begins when the individual enrolls in Medicare Part B. These members are only eligible to purchase the CareFirst MedPlus Plan A.

Delaying Enrollment in Medicare Part B

The size of the employer determines whether the beneficiary may be able to delay Part A and Part B without having to pay a penalty if they decide to enroll in Medicare later.

If the employer has fewer than 20 employees, the beneficiary should sign up for Part A and Part B when they are first eligible. Otherwise, they may have to pay a Part B late enrollment penalty and they may have a gap in coverage if they decide to delay enrollment.

The Part B premium penalty is 10% for each 12 month-period that they were eligible for Part B and did not sign up. The monthly Part B will reflect the late enrollment penalties.

If the employer has 20 or more employees, and the beneficiary has group health coverage based on current employment, they may be able to delay Part A and Part B and will not have to pay a lifetime late enrollment penalty if they enroll later. If they are eligible for premium-free Part A, they can enroll in Part A at any time after they are first eligible for Medicare.

If the beneficiary signs up for Part B during a Special Enrollment Period, they do not usually pay a late enrollment penalty. The beneficiary will have 8 months to sign up for Part B without a penalty, whether they choose COBRA or not.

CareFirst MedPlus

The CareFirst MedPlus plans are offered in the following jurisdictions as follows:

- Maryland
- District of Columbia
- Virginia—portions of Northern Virginia East of Route 123

Nine products in Maryland are sold under the legal entity First Care, Inc. Key features include:

- Annual or Monthly Electronic Funds Transfer (EFT) premium payment
- SilverSneakers Fitness Program
- Geographical Rating
- Household Discount

CareFirst's MedPlus Portfolio

CareFirst sells nine of the twelve standardized Medicare Supplement plans, and they are:

1. Plan A
2. Plan B
3. Plan F*
4. High Deductible Plan F*
5. Plan G
6. High Deductible Plan G
7. Plan L
8. Plan M
9. Plan N

*Due to MACRA legislation of 2015, Plan F and High Deductible F will only be available for sale to individuals eligible for Medicare before 1/1/2020.

Key Differences Between MedPlus Plan G and MedPlus High-Deductible Plan G

MedPlus Plan G

Plan G offers a high level of protection against high medical expenses. Plan G covers all the gaps of Medicare, including Medicare Part A and Part B deductibles, co-payments and coinsurance established by Medicare after Part B deductible is met. Covers 20% of charges for medical expenses after Medicare's Part B deductible.

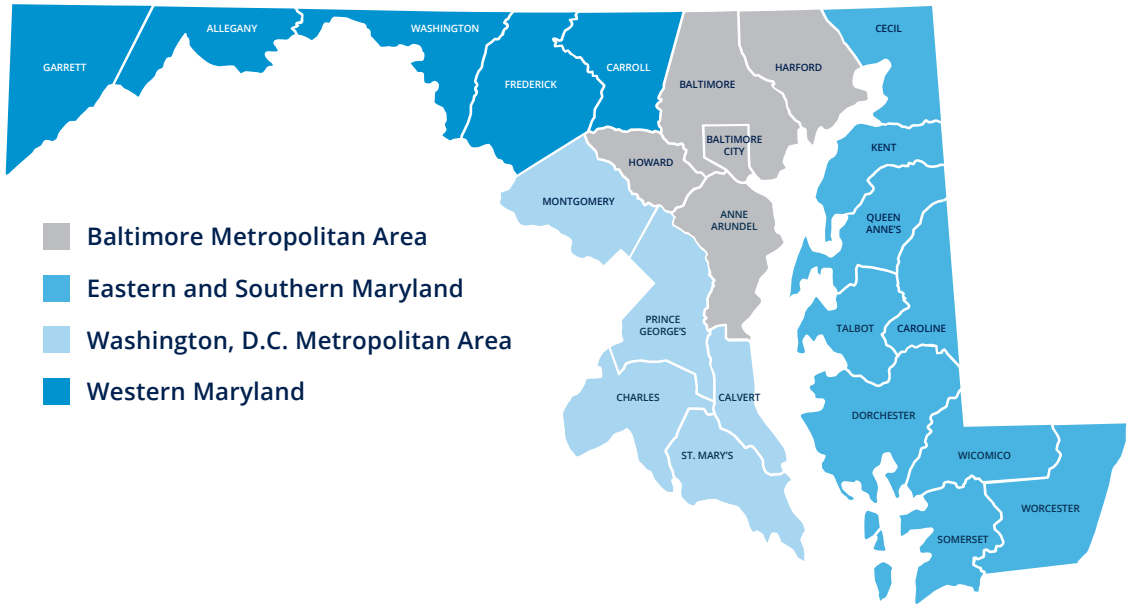
MedPlus High-Deductible Plan G

High-Deductible Plan G is our lowest premium plan. After the member meets the $2,490 plan deductible, hospital and medical co-payments and coinsurance are covered 100% by the plan. The member is subject to the Part B deductible, but it counts towards meeting the $2,490 plan deductible.

Current Medigap MedPlus member moving out-of-state

If a subscriber moves out of the First Care service area, they will be able to retain their most recent geographic region (and the corresponding factor) upon policy renewal. The member will be covered out of state if they see a provider who accepts Medicare assignment.

Maryland Geographical Rating Areas for CareFirst MedPlus Plans



CareFirst MedPlus Available Discounts

Two (2) types of discounts are available:

1. Household (HH) Discount
2. Annual or Monthly Electronic Funds Transfer (EFT) premium payment

CareFirst MedPlus Household Discount

CareFirst's MedPlus subscribers are eligible for a 10% discount off the monthly premium when:

- they initially enroll, or their plan is renewed
- they and another CareFirst MedPlus subscriber reside at the same address, and
- both are actively enrolled in a CareFirst MedPlus policy.

The CareFirst MedPlus application includes the following new section: **1D. HOUSEHOLD INFORMATION (IF APPLICABLE).** This will be used to collect data to determine eligibility for the new HH Discount.

1D. HOUSEHOLD INFORMATION (IF APPLICABLE)	
The following information will be used to collect data to determine eligibility for the Household Discount. If you reside in the same household as another CareFirst MedPlus member, please provide their information below:	
Last Name:	First Name:
Date of Birth: _____ / _____ / _____ Month Day Year	Subscriber ID# (optional):
◯ Check to confirm that your address is the same as the CareFirst MedPlus member you listed.	

CareFirst MedPlus Household (HH) Discount Eligibility

To be eligible to receive the HH Discount, the following criteria must be met:

- Two enrollees per household are required *(they do not have to be married).*
- Both must be enrolled in a CareFirst MedPlus plan.

NOTE: The discount is limited to **two** actively enrolled CareFirst MedPlus subscribers who reside at the same residence. If two subscribers in the same household already receive the HH Discount, all additional household persons are no longer eligible.

CareFirst MedPlus Household (HH) Discount Ineligibility

Subscribers can be deemed ineligible for the HH Discount for any of the following reasons:

- Neither subscriber is in a CareFirst MedPlus product.
- One of the subscribers already has a HH Discount with someone else.
- The address for the second subscriber does not match the address of the current subscriber.
- There are two subscribers in the same household already receiving the MedPlus HH Discount.
- Eligibility could not be determined with the information provided.

If a subscriber is deemed ineligible for the HH Discount, then they will receive the **Household Ineligibility Letter**.

Discount Renewal Verification

When members' plans renew, CareFirst will verify eligibility for the HH Discount.

If the Member...	Then...
Continues to qualify	No changes will be made to the policy.
No longer qualifies	■ The member who is renewing will be marked as ineligible and will have their HH Discount removed. ■ The house mate will be flagged as ineligible and, upon their renewal, they will lose their HH Discount.

NOTE: If a member changes plans mid-year, CareFirst will revalidate their eligibility for the HH Discount.

If CareFirst cannot determine eligibility based on the information provided in the application, the applicant will receive the **Household Ineligibility Letter** along with a **Household Discount Request Form** so that the applicant can re-submit the information.

Household (HH) Discount Scenarios

Three (3) scenarios are outlined below that should clarify the process.

If 2 applicants apply for a CareFirst MedPlus plan...	Then, are they eligible for the HH Discount?	Example: Mary and Tom live at the same residence, but they do NOT have a CareFirst MedPlus plan.
For different effective dates	Applicant #1 will not be eligible because the Applicant #2 is not in the system yet. Applicant #2 will qualify because Applicant #1 is in the system. The discount will be applied to the effective date of Applicant #2's CareFirst MedPlus plan. Applicant #1 will be marked as eligible due to the Second applicant existing in the system but the HH Discount will not be applied until his/her renewal.	Tom applies for a CareFirst MedPlus plan for a 10/1 effective date. **Note:** Since Mary is not in the system with a CareFirst MedPlus plan, Tom is not eligible for the HH Discount. Mary then applies for a CareFirst MedPlus plan for an 11/1 effective date. **Note:** Since Tom is in the system with a CareFirst MedPlus plan AND shares the same residence with Mary, she will receive the HH Discount with an 11/1 effective date. Tom will now be flagged as eligible for the HH Discount; however, it will not be applied until his renewal.
For the same effective date	Yes, both applicants will receive the HH Discount	Mary and Tom both apply for a CareFirst MedPlus plan for a 10/1 effective date. Since both Mary and Tom are both getting a CareFirst MedPlus plan AND share the same residence, they both will receive the HH Discount with a 10/1 effective date.
For staggered effective dates	Yes, both applicants will receive the HH Discount	Tom applies in early August for a CareFirst MedPlus plan for a 10/1 effective date. **Note:** Since Mary is not in the system with a CareFirst MedPlus plan, Tom is not eligible for the HH Discount. Mary then applies in late August for a CareFirst MedPlus plan for a 9/1 effective date. **Note:** Since Tom is in the system with a CareFirst MedPlus plan AND shares the same residence with Mary, Mary will receive the HH Discount with a 9/1 effective date. Tom will now be flagged as eligible for the HH Discount and will receive the discount because his 10/1 effective date has not started, and Mary is now in the system with a CareFirst MedPlus plan sharing the same residence.

Annual Payment or Electronic Funds Transfer (EFT) Discounts

CareFirst MedPlus will offer a $2 off monthly premium rate *or* $24 off annual premium rate for subscribers if they do either of the following:

- Select automated payment via checking/ savings account *($2 off monthly premium)*; or
- Elect the annual payment option *($24 off annual premium)*

NOTE: Applicants will be quoted the base rate. They will see any applicable discounts they qualify for in the first invoice.

Electronic Funds Transfer (EFT) Member Reminders

By completing an application and choosing the automated payment via bank withdrawal option, the member also agrees to no longer receive paper invoices.

From the application: *"Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at* www.carefirst.com/myaccount*."*

- A member can sign up for the automated bank draft payment option at any time via *My Account*.
- If a member initially has the automated payment option and later revert back to a different payment method, they will lose the discount.

SilverSneakers® Fitness Program for CareFirst MedPlus plans

SilverSneakers* is a comprehensive program that improves overall well-being, strength and social aspects. Designed for all levels and abilities, this program is provided by CareFirst MedPlus at no additional cost.

SilverSneakers provides access to fitness equipment, group exercise classes, social networking, online education and a sense of community. With membership to thousands of gym and fitness centers nationwide, members can visit any one of the locations at any time.* SilverSneakers also provides digital resources through SilverSneakers LIVE™ virtual classes, SilverSneakers On-Demand™ videos available 24/7 and a mobile app, SilverSneakers GO™.

Highlights include:

- Access to fitness equipment
- Specially designed, signature exercise classes for all fitness levels***
- Pools, tennis courts and walking tracks***
- Thousands of fitness and community locations nationwide (enroll at multiple locations)
- Social events in the community
- Online resources with nutrition and fitness tips
- Customer Service support at 866-584-7389

Dental and Vision Plans are Available

Dental—A dental plan can be added to CareFirst MedPlus Coverage at an additional cost.

Vision—A vision plan can be added to CareFirst MedPlus Coverage at an additional cost.

For additional details, see CareFirst.com/for brokers/individual applications and forms.

*SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved.

**Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of L basic membership. Facilities and amenities vary by PL.

***Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

2022 Original Medicare vs. Medicare Supplement Member Responsibility

	Original Medcare alone	MedPlus Plan A	MedPlus Plan B	MedPlus Plan F	MedPlus High-Deductible Plan F*	MedPlus Plan G	MedPlus High-Deductible Plan G*	MedPlus Plan L**	MedPlus Plan M	MedPlus Plan N
Hospital Services (Part A)										
Inpatient Hospital Deductible	$1,556	$1,556	$0	$0	$0 after plan deductible	$0	$0 after plan deductible	$389	$778	$0
Hospitalization days 61-90	$389	$0	$0	$0	$0 after plan deductible	$0	$0 after plan deductible	$0	$0	$0
Hospitalization days 91+ (while using 60 lifetime reserve days)	$778	$0	$0	$0	$0 after plan deductible	$0	$0 after plan deductible	$0	$0	$0
365 days after hospital benefits stop	All costs	$0	$0	$0	$0 after plan deductible	$0	$0 after plan deductible	$0	$0	$0
Skilled Nursing Facility days 21 through 100	$194.50	$194.50	$194.50	$0	$0 after plan deductible	$0	$0 after plan deductible	Up to $48.63 a day for days 21 - 100	$0	$0
Medical Expenses (Part B)										
Medical expense deductible	$233	$233	$233	$0	$0 after plan deductible	$233	$2,490 after $233 Part B deductible	$233	$233	$233
Medical expenses after deductible	20%	0%	0%	0%	0% after plan deductible	0%	0% after plan deductible	5%	0%	OV up to $20 ER up to $50
Excess charges above Medicare approved amounts	100%	100%	100%	$0	0% after plan deductible	$0	0% after plan deductible	100%	100%	100%
Other Expenses										
Foreign country emergency care (beginning during the first 60 days of each trip outside the USA)	100%	100%	100%	$250 deductible, then 20%	$250 deductible after plan deductible, then 20%	$250 deductible, then 20%	$250 deductible after plan deductible, then 20%	100%	$250 deductible, then 20%	$250 deductible, then 20%

Dollar amounts shown are the 2022 deductibles, copayment and coinsurance. These amounts may change on January 1, 2023.

*With High-Deductible Plan F and High-Deductible Plan G there is an annual plan deductible of $2,490. For High-Deductible Plan F, after you meet the $2,490 annual plan deductible, you pay $0. For High-Deductible Plan G, Part B deductible counts towards meeting the $2,490 deductible. If the $2,490 deductible is met with all Part A expenses and Part B deductible expenses are then incurred, the beneficiary must pay the Part B deductible for these expenses to be covered.

**With Plan L, there is an out-of-pocket limit of $3,310. After you meet the out-of-pocket limit, you pay $0.

***Up to $50,000 lifetime maximum.

Medical Underwriting Overview

MedPlus Applicants

If the applicant inquiring to enroll in a MedPlus product, they are subject to Medical Underwriting if the applicant meets one of the criteria listed below.

- Outside of the Guarantee Issue or Open Enrollment Period
- Disabled and under the age of 65
- Under age 65 disabled individuals who are eligible for Medicare and turn 65 will be eligible for a 6 month Guaranteed Issue Period and qualify for Level 1 rates during this period.
- Section 4A—answering "yes" disqualifies the application for coverage as noted on the application.
- Section 4B, 4C, 4D, 4E—answering "yes",
- medical underwriting would review the complexity of the condition.
- If an existing CareFirst MedPlus subscriber

wishes to change their CareFirst MedPlus plan, then medical underwriting would apply if they want to move to a richer plan.

- All pre-CareFirst MedPlus Medicare
- Supplement members (prior to launch of CareFirst MedPlus 2016) must undergo medical underwriting to apply for a CareFirst MedPlus plan.
- The member should NOT terminate their original coverage until the results of medical underwriting for the new plan are known.

All Members who apply for a plan change that requires medical underwriting must be informed of the following:

1. The potential outcomes of medical underwriting so the member can decide whether to continue pursuing a plan change.

   Based upon medical underwriting, the plan the member is coming from, and the plan selected, the member may get a lower rate, a higher rate or be "denied" for the new CareFirst MedPlus plan.

2. The member should NOT terminate their original coverage until the results of medical underwriting for the new plan are known.
3. The member ALWAYS has the right to remain in his/her original plan:
   - If the member is denied coverage under medical underwriting, they will remain in their original coverage.
   - Once the new coverage has been approved by Medical Underwriting, the member is termed from their original coverage. If the member wants to remain in their original coverage (e.g., the rate for the new plan is higher), the member has 30 days from the effective date of the new policy to contact Customer Service and request to be placed back into their original policy/coverage.

Current CareFirst Medicare Supplement members (closed block) and not enrolled in MedPlus Medicare Supplement

All current CareFirst Medicare Supplement members in our closed block who apply for a plan change to a MedPlus plan will require medical underwriting. These members must be informed of the following.

- The potential outcomes of medical underwriting so the member can decide whether to continue pursuing a plan change.

Based upon medical underwriting, the plan the member is coming from, and the plan selected, the member may get a lower rate, a higher rate or be "denied" for the new CareFirst.

- The member should NOT terminate their original coverage until the results of medical underwriting for the new plan are known.
- The member ALWAYS has the right to remain in his/her original plan:
  - If the member is denied coverage under medical underwriting, they will remain in their original coverage. Once the new coverage has been approved by Medical Underwriting, the member is termed from their original coverage. If the member wants to remain in their original coverage (e.g., the rate for the new plan is higher), the member has 30 days from the effective date of the new policy to contact customer service and request to be placed back into their original policy/coverage.

Subsequent Enrollment: Is Medical Underwriting Required?

- For members currently enrolled in one of our MedPlus plans wanting to change to another MedPlus plan, CareFirst will only medically underwrite applicants who move into a "richer" plan.
- For MD, applicants moving from GHMSI or CFMI Legal Entity into a First Care Legal Entity will be medically underwritten regardless of whether the MedPlus plan is richer or not, unless they qualify for the Open Enrollment/Guarantee Issue.
- For MD, applicants moving from a GHMSI or CFMI Legal Entity into the First Care Legal Entity must reapply for a vision benefit if it existed on their current plan.
- For DC and VA, applicants moving from a GHMSI Plan into the First Care Legal Entity will be medically underwritten regardless of whether the MedPlus plan is richer or not.
- For DC and VA, applicants moving from a GHMSI Plan into the First Care Legal Entity shall retain his/her vision coverage if it existed on the grandfathered plan.

See the matrix regarding movement within the CareFirst MedPlus plans on page 15.

Medical Underwriting & Plan Movement

See the chart below to determine if medical underwriting is required when moving from one MedPlus plan to another MedPlus plan.

NOTE: The chart refers to those that DO NOT qualify for Open Enrollment or for the Guaranteed Issue Period over 6 months past the Part B effective date (Open Enrollment) or OUTSIDE of Guaranteed Issue Period.

Move within CareFirst MedPlus MD,DC and VA IS MEDICAL UNDERWRITING REQUIRED?									
From a MedPlus Plan:	Moving to:								
	High Ded G	High Ded F	Plan A	Plan N	Plan L	Plan B	Plan M	Plan G	Plan F
High Ded G		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
High Ded F	No		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Plan A	No	No		Yes	Yes	Yes	Yes	Yes	Yes
Plan N	No	No	No		Yes	Yes	Yes	Yes	Yes
Plan L	No	No	No	No		Yes	Yes	Yes	Yes
Plan B	No	No	No	No	No		Yes	Yes	Yes
Plan M	No	No	No	No	No	No		Yes	Yes
Plan G	No	No	No	No	No	No	No		Yes
Plan F	No	No	No	No	No	No	No	No	

Medical Underwriting Guidelines

In 2018, CareFirst expanded Level 1 rating to beneficiaries who are 7 months to 10 years outside of their Guaranteed Issue Period.

Individuals may receive the lowest rate for up to 10 years from their Part B effective date.

Those enrolled in a competitor's plan can apply and potentially receive a more competitive rate upon medical underwriting review.

CareFirst Medical Underwriting Guidelines			
Time since 65th birthday or Medicare Part B effective date	**Smoker**	**Medical Underwriting**	**Rating Level**
0 to < 7 Months	N/A	Guaranteed issue	Level 1
7 Months to < 10 Years	No	No medical issue or Hypertension or Hypercholesterolemia Disorder (w/ 0–1 medications)	Level 1
		Minor Medical Issue or Hypertension or Hypercholesterolemia Disorder (w/ 2 medications)	Level 2
		Major Medical Issue	Level 3
		Extreme Medical Issue	Denied
	Yes	No/Minor Medical Issue	Smoker Level 2
		Major Medical Issue	Smoker Level 3
		Extreme Medical Issue	Denied
10 Years or More	No	No/Minor Medical Issue	Level 2
		Major Medical Issue	Level 3
		Extreme Medical Issue	Denied
	Yes	No/Minor Medical Issue	Smoker Level 2
		Major Medical Issue	Smoker Level 3
		Extreme Medical Issue	Denied

Prospective Members Special Guarantee Issue Period (SGIP)

If prospective members are outside of their initial open enrollment period (6 months from their Medicare Part B effective date), then they may qualify for a Special Guarantee Issue Period (SGIP) and Level 1 Rating if one of the below circumstances exists:

- Their supplemental coverage with an employer group health plan has been terminated within the last 63 days, or
- They enrolled with Medicare Advantage plan, but decided to switch to a Medigap plan after being in the Medicare Advantage plan for less than 12 months.

See Section 3. Eligibility Information listed in the MedPlus application below.

SECTION 3. ELIGIBILITY INFORMATION (CONTINUED)	
WITHIN THE PAST 63-DAY PERIOD WERE YOU ENROLLED UNDER:	
2. A Medicare health plan* such as a Medicare Advantage Plan or you are 65 years of age or older and enrolled with a Program of All-Inclusive Care For the Elderly (PACE) and at least one of the following was met: a. The plan was terminated, no longer provides or has discontinued the plan in the service area where you live. b. You were not able to continue coverage with the plan because you moved out of the plan's service area or other change in circumstances specified by the Secretary of the Department of Health and Human Services (HHS). This does not include failure to pay premiums on a timely basis. c. You are leaving because you can show that the plan substantially violated a material provision of the policy including not providing medically necessary care on a timely basis or in accordance with medical standards. d. You are leaving because you can show that the plan or its agent misled you in marketing the policy. e. The certification of the organization was terminated. f. You meet any other exceptional condition as the Secretary of the Department of HHS may provide.	◯ Yes ◯ No
3. A Medicare Supplement policy and your enrollment ended and at least one of the following was met: a. Through no fault of your own, or because your insurance company has gone bankrupt and you lost coverage, or is going bankrupt and you will be losing your coverage. b. You are leaving because you can show that the company substantially violated a material provision of the policy. c. You are leaving because you can show that the company or its agent misled you in marketing the policy.	◯ Yes ◯ No
4. A Medicare health plan* such as a Medicare Advantage or PACE plan that you joined when you first enrolled under Medicare Part B at age 65 or older, and within 12 months of enrolling you decided to switch to a Medicare Supplement policy.	◯ Yes ◯ No
5. A Medicare Supplement plan that you dropped and subsequently enrolled for the first time with a Medicare health plan* such as Medicare Advantage or PACE plan; and you have been in the plan less than 12 months and want to return to a Medicare Supplement plan.	◯ Yes ◯ No
6. A Medicare Part D plan, and ALSO were enrolled under a Medicare Supplement plan that covers outpatient prescription drugs. When you enrolled in Medicare Part D, you terminated enrollment in the Medicare Supplement plan that covered outpatient prescription drug coverage.	◯ Yes ◯ No
7. An employer group health plan or union coverage that provides health benefits and the plan terminated, and solely because of your Medicare eligibility, you are not eligible for the tax credit for health insurance costs (under Section 35 of the Internal Revenue Code).	◯ Yes ◯ No

Resources

Medicare

- Phone: **800-MEDICARE** (633-4227)
- Hours: 24 hours/day, 7 days/week
- Web address: **www.medicare.gov**

Medicare.gov

- Medicare & You (updated each year by CMS)
- Web address: **www.medicare.gov/medicare-and-you**

Social Security Administration

- Phone: **800-772-1213**
- Hours: 7am – 7pm, Mon. – Fri.
  (automated service is available 24 hours/day, 7 days/week)
- Web address: **www.ssa.gov**

First Care, Inc.
10455 Mill Run Circle
Owings Mills, MD 21117-5559

CareFirst MedPlus

CONNECT WITH US:

This document was created for informational purposes only and is not intended to provide legal and/or accounting advice and should not be relied upon as such. Individuals and Producers should consult with their own accountants and/or legal counsel if they have any questions regarding the financial and legal impacts of the Affordable Care Act.

BMO65 (7/22)