1. Module 2: Part C and Other Medicare Health Plans

2. Navigation Instructions

3. Terms and Conditions

4. Learning Objectives

- After reviewing "Part 2: Medicare Health Plans" you will be able to:
  - Explain what types of Medicare health plans are available
  - Explain who is eligible for the different types of plans
  - Describe the different types of Special Needs Plans (SNPs)
  - Describe features of different Medicare health plan types
  - Describe the different types of benefits offered by Medicare Advantage plans
  - Explain how Medicare health plans work with prescription drug plans
  - Explain enrollee rights concerning their Medicare health plan

5. Training Roadmap: Module 2

- Medicare Advantage Plans
- MA Plan Types: Coordinated Care Plans
- Special Needs Plans
- MA Plan Types: Private Fee-for-Service (PFFS) Plans
- MA Plan Types: Medical Savings Account (MSA) Plans
- Medicare Advantage Employer/Union Plans
- Medicare Advantage: Eligibility, Costs, and Benefits
- Medicare Advantage Plans and Qualified Medicare Beneficiaries
- Medicare Advantage and Prescription Drugs
- Other Types of Medicare Health Plans
- Enrollee Protections: Appeals and Grievances

6. Title Page: Medicare Advantage Plans

7. Part C: Medicare Advantage Plans: Overview

Under the Medicare Advantage (MA) program, known as Medicare Part C, private companies offer health plans that cover all Medicare Part A and Part B benefits.

- Many also cover Part D prescription drug benefits (MA-PD plans)
- All MA plans have a maximum out-of-pocket limit (MOOP) for basic benefits
- Many MA plans also offer additional benefits that Medicare does not cover, known as supplemental benefits.
- The types of Medicare Advantage (MA) plans are:
    - Coordinated Care Plans. These plans have a network of preferred providers and include:
        - Health Maintenance Organizations (HMOs), some have a point-of-service (POS) benefit that allows beneficiaries to go out-of-network subject to limitations
        - Preferred Provider Organizations (PPOs), which may be local or regional
    - Private Fee-for-Service (PFFS) Plans
    - Medical Savings Account (MSA) Plans

8. Title Page: MA Plan Types Coordinated Care Plans

9. MA Plan Types Coordinated Care Plans – HMOs

- HMOs generally only cover services furnished by doctors and hospitals within the plan's network (known as participating providers). However, there are certain exceptions:
    - Emergency services furnished by out-of-network providers are covered.
    - When the enrollee is temporarily absent from the plan's service area, dialysis services are covered outside of the network**.**
    - Urgently needed services furnished by out-of-network providers are covered when the enrollee is temporarily outside of the service area or in rare circumstances when the network is not available.
    - If a needed specialist or a covered procedure is not available through participating providers, the HMO plan will authorize out-of-network services.
- HMO enrollees may need to select a primary care doctor and may need a referral for specialty care to be covered.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to out-of-network doctors and hospitals without receiving prior approval for certain services.
    - Unlike a PPO, an HMO-POS plan may limit the services available out-of-network or may put a dollar cap on the amount of out-of-network coverage.
    - Cost-sharing is generally higher for services furnished by out-of-network providers than for services obtained from participating providers.

10. MA Plan Types Coordinated Care Plans – PPOs

Under a PPO, enrollees:

- may get care from any provider in the U.S. who accepts Medicare; they are not limited to participating providers.
- do not need a referral to see an out-of-network provider but are encouraged to contact the plan to be sure the service they wish to obtain out-of-network is medically necessary and will be covered.
- usually pay higher cost-sharing amounts to receive services from an out-of-network provider than from a participating provider.

Regional PPOs are PPOs that are offered throughout an entire region, made up of one or more states.

11. MA Plan Types Coordinated Care Plans – Special Needs Plans

- Special Needs Plans (SNPs) are a type of Medicare Advantage coordinated care plan (HMOs or PPOs) that are specially designed to serve a subset of Medicare beneficiaries.
- In addition to meeting all other MA eligibility criteria, beneficiaries must also meet criteria specific to the type of SNP in which they wish to enroll.
- All SNPs must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees.
- All SNP plans include prescription drug coverage.

12. Title Page: Special Needs Plans

13. Special Needs Plans –Types (1 of 2)

There are several types of Special Needs Plans

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to individuals with certain chronic or disabling chronic conditions, such as diabetes, certain cardiovascular disorders, cancer, certain chronic lung disorders, HIV, dementia, end-stage renal disease (ESRD) requiring dialysis, or certain other conditions.
    - Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.
- Institutional SNPs (I-SNPs) are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility (NF) as defined under Medicaid law, an intermediate care facility for the individuals with intellectual and developmental disabilities, a long-term care hospital, an inpatient psychiatric facility, or certain other facilities specified by CMS.
- Institutional Equivalent (IE) SNPs enroll MA eligible individuals who live in the community but require an institutional level of care (i.e., are determined by an impartial entity to need the level of services furnished by the types of facilities listed above). Eligibility for an IE-SNP may be limited to certain assisted living facilities.

14. Special Needs Plans –Types (2 of 2)

- Dual-eligible SNPs (D-SNPs) enroll certain categories (as determined by each state) of dual eligible beneficiaries.
- Dual eligible beneficiaries are those who qualify for both Medicare and Medicaid. They include beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or Medicaid assistance with Medicare premiums or cost-sharing.
- The categories of dual eligibles include the following:
  - Qualified Medicare Beneficiaries (QMBs) -- Medicaid helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs for these beneficiaries.
  - Specified Low-Income Medicare Beneficiaries (SLMBs): Medicaid helps pay Part B premiums for these beneficiaries.
  - Qualifying Individuals (QIs): Medicaid helps pay Part B premiums for these beneficiaries.
  - Qualified Disabled Working Individuals (QDWIs) -- Medicaid pays the Part A premium for certain disabled and working beneficiaries.
- Dual eligible individuals may also be eligible for full Medicaid benefits. Such individuals are known as full-benefit dual eligible (FBDEs).

15. D-SNPs

There are different types of D-SNPs, including:

- fully integrated dual-eligible (FIDE) D-SNPs, which provide dual-eligible enrollees coordinated access to Medicare and Medicaid benefits (including Medicaid primary care acute care, and long-term services and supports) under a single organization that has a Medicare Advantage and Medicaid managed care contract.
- highly integrated dual-eligible (HIDE) D-SNPs, which cover Medicaid benefits under a capitated contract between the State Medicaid agency and the MA organization, the MA organization's parent organization, or an affiliate. HIDE SNPS cover long-term services and support, or behavioral health services.
- coordination-only D-SNPs, which are not FIDE or HIDE D-SNPs and generally have certain obligations to notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for certain high-risk full-benefit dual eligible individuals.

16. Title Page: MA Plan Types: Private Fee-for-Service (PFFS) Plans

17. MA Plan Types: Private Fee-for-Service (PFFS) Plans (1 of 2)

- Individuals enrolled in PFFS plans may receive covered services from any provider in the U.S. who is eligible to provide Medicare services and agrees to accept the plan's terms and conditions of payment. They are not limited to receiving services from a network of plan providers.
- Some PFFS plans contract with providers. If the PFFS plan has a network, enrollees may pay more if they see out-of-network providers.

- Except for emergencies, enrollees must inform providers before receiving services that they are a PFFS plan member (typically by showing their membership card), so the non-network providers can decide whether to accept the plan's terms and conditions.
- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees. Therefore, an enrollee needs to confirm that their provider of choice will accept a PFFS plan before enrolling in one.

18. MA Plan Types: Private Fee-for-Service Plans (2 of 2)

- Providers are prohibited from charging a PFFS enrollee more than the cost-sharing specified in the PFFS plan's terms and conditions of payment.
    - Cost-sharing may include balance billing up to 15% of the Medicare rate only if allowed in the plan's terms and conditions of payment.
        - Balance billing happens when a doctor is eligible to accept Medicare but is not a Medicare "participating" provider under Original Medicare. Under Original Medicare, these non-participating providers are allowed to balance bill beneficiaries up to 15% over the Medicare payment amount.
        - PFFS plans may choose whether or not to allow non-participating providers to balance bill their members.
- PFFS plans may choose to offer Part D benefits but are not required to do so.

19. Title Page – MA Plan Types: Medicare Savings Account Plans

20. MA Plan Types: Medical Savings Account (MSA) Plans

- A Medicare MSA is a high-deductible health plan that is combined with a special medical savings account.
    - Medicare contributes money to the beneficiary's medical savings account to assist with paying for Medicare covered services during the deductible phase.
    - The amount of the contribution varies by plan.
    - Money left in the account at the end of the year stays there. If the beneficiary remains enrolled in the plan the following year, Medicare will add any new deposits.
- If an MSA enrollee uses all the funds in their medical savings account, they must pay out-of-pocket until they reach their deductible.
- After the annual deductible is met, the plan pays 100% for covered services.
    - The maximum allowable deductible for MSA plans in 2024 is $16,000. However, most MSAs will have a substantially lower deductible.

21. MA Plan Types: MSA Plans

- There is no premium for an MSA, MSA plans cover Part A and Part B benefits, but beneficiaries must continue paying their Part B premium.
- MSAs do NOT cover Part D Medicare prescription drug benefits.
    - MSA enrollees must enroll in a stand-alone PDP if they want prescription drug benefits.
- MSA enrollees may receive covered services from any Medicare approved provider in the U.S. if the provider chooses to accept their plan.
- MSAs may not have a network or may have a full or partial network of providers.
- All non-network providers must accept the same amount that Original Medicare would pay them as payment in full. This is the amount the enrollee will pay the provider before the deductible is met.

22. Title Page: Medicare Advantage Employer/Union Plans

23. Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
    - Medicare Advantage individual plans (plans open to the public).
    - Medicare Advantage plans that are only available to individuals based on their employer, known as **Employer Group Waiver Plans or EGWPs**.
    - A Medicare Advantage plan through a direct contract between the employer or union and CMS, known as a direct contract plan.
- Employers with less than 20 employees (as calculated under Medicare secondary payor rules) may be able to offer Medicare Advantage plans to their active employees and their dependents.
- Any size employer can offer Medicare Advantage plans to its retirees and their dependents.
- EGWP and direct contract plans are different than other Medicare Advantage plans because eligibility to enroll is limited to certain active employees, retirees, and their dependents, and because a variety of regulatory requirements are waived as they apply to the plans.

24. Title Page: Medicare Advantage Plans – Eligibility, Costs, and Benefits

25. Medicare Advantage Eligibility

To be eligible to enroll in a Medicare Advantage plan:

- A beneficiary must be entitled to Part A ***and*** enrolled in Part B.
- The beneficiary must permanently live in the MA plan's service area. (If a beneficiary spends six months or more outside of the plan's service area, they should only enroll in MA-PD plans with a visitor/traveler benefit.)
- Be a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination.)

- MA plans must generally enroll any eligible beneficiary who applies regardless of health status.
    - Special needs plans only enroll beneficiaries within their targeted populations.
    - Employer group waiver plans (EGWPs) or direct contract plans may only enroll Medicare beneficiaries who are active employees or retirees of the employer or union offering the plan and their dependents.

- An individual can sign up for Medicare through the Social Security Administration.

26.MSAs: Special Eligibility Rules

The following individuals are ***not*** eligible to enroll in an MSA:

- An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan. Examples include, but are not limited to, primary health care coverage other than Medicare, Medicare hospice, certain supplemental insurance policies, and retirement health benefits.
- An individual who is enrolled in a Federal Employee Health Benefits plan or is eligible for health care benefits through the Veteran's Administration.
- Dual eligibles entitled to coverage of Medicare cost-sharing under Medicaid.
- An individual who cannot provide assurances that they will reside in the United States for at least 183 days during the year for which the election is effective.
- An individual who has already elected hospice.

27. Medicare Advantage Plans: Premiums and Cost-Sharing

- Medicare Advantage Plans may charge a premium. If the plan charges a premium, beneficiaries must generally continue paying their Part B premium in addition to paying the monthly plan premium to remain enrolled.
- Medicare Advantage plans may also require their members to pay for a portion of the covered services they receive. This is known as member cost-sharing. There are several potential types of cost-sharing:
    - Deductible: A set amount the member must pay for covered services before the health plan begins paying for those services.
    - Copayment: A fixed dollar amount per service the member must pay. For example, $20 for each visit to a primary care provider, or $30 for each visit to a specialist.
    - Coinsurance: A percentage of the cost of the service the member must pay. For example, 20% of the cost of durable medical equipment.

28. Maximum Out-of-Pocket Limits

- All Medicare Advantage plans must have a “maximum out-of-pocket” limit (known as the “MOOP”) for Part A and Part B benefits. That is, once the member pays a specified amount of cost-sharing, the health plan covers 100% of covered medical services. Each year CMS specifies a mandatory MOOP, which health plans cannot exceed, although they may have a lower MOOP.
    - Each plan’s MOOP will be specified in its summary of benefits and its evidence of coverage.
- For 2025, the maximum MOOP limit for Medicare Advantage coordinated care plans and private fee-for-service plans is $9,350, although most plans will have lower limits. PPOs must also have an aggregate MOOP for network and non-network providers of $14,000 in 2025. Again, it is likely that many will have lower limits.
- As previously noted, MSAs have a deductible that members must pay, then the plan pays 100% for covered services.

29. Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- Most Medicare Advantage plans also cover part of the Original Medicare cost-sharing for Part A and Part B benefits.
- Medicare Advantage plans may also cover extra benefits not covered by Original Medicare (known as "supplemental benefits"), such as:
    - Vision Services, including glasses
    - Hearing Aids
    - Routine Dental Services
- Supplemental benefits may be optional or mandatory.
    - Mandatory supplemental benefits are embedded in the Medicare Advantage plan and must be purchased as part of the plan. They can include reductions in cost-sharing for benefits under Original Medicare.
    - Optional supplemental benefits may be added to an MA plan at the option of the beneficiary.

30. Special Benefits Depending on Chronic Health Condition

Medicare Advantage plans may offer special benefits for individuals with certain chronic health conditions, such as diabetes, heart failure, COPD, or other conditions, that are not available to members of the same plan without the specified condition. There are two categories of such benefits: (1) those that are primarily health related and (2) those that are not (the latter generally address social determinants of health and are known as Special Supplemental Benefits for the Chronically Ill, or SSBCI).

- Primarily health related benefits for chronically ill enrollees may include items such as decreased cost-sharing for certain services, or supplemental benefits (e.g., at-home palliative care or transportation to medical appointments).
- SSBCI may include items such as groceries, meals beyond a limited basis, pest control, and non-medical transportation.

Consequently, it is useful for agents to know if their clients have conditions that may qualify them for these types of benefits if they are available in the clients' area.

31. Medicare Advantage Plans – Utilization Management

- Medicare Advantage plans may implement mechanisms to manage the utilization of covered services.
- Such mechanisms include requiring a referral or prior authorization to obtain a service.
    - PPOs may not require prior authorization for out-of-network services.
    - PFFS plans may not require prior authorization.
    - Non-network MSAs may not require prior authorization.
- Plans may also implement step therapy requirements for Part B or Part D drugs. Step therapy is when a plan requires a beneficiary to try less expensive options before "stepping up" to drugs that cost more.
- When an enrollee has enrolled in an MA plan after starting a course of treatment, there is a minimum 90-day transition period during which the MA organization may not disrupt or require

reauthorization for the active course of treatment for new plan enrollees, even if they are receiving the services from a non-network provider.

32. Title Page - Medicare Advantage Plans and Qualified Medicare Eligible Beneficiaries

33. MA Plans and Qualified Medicare Beneficiaries (QMBs)

As previously noted, QMBs are a type of dual eligible beneficiary. Special rules apply to QMBs enrolled in any type of MA plan:

- When a QMB enrolls in an MA plan, the beneficiary does not have to pay more cost-sharing than any minimal copayment that would apply under Medicaid.
- All providers (whether or not they are Medicaid participating, or in-network) are prohibited by law from balance billing QMBs for any Medicare cost-sharing amounts. Providers who balance bill are subject to sanctions.

34. Title Page - Medicare Advantage and Prescription Drugs

35. MA & Prescription Drugs

- An organization offering coordinated care MA plans must offer at least one MA plan with prescription drug coverage (known as an MA-PD plan) in every service area.
- MA PFFS plans have the option of offering prescription drug coverage but are not required to do so.
    - An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract, the organization offers another PFFS plan that includes a Part D benefit.
- MA MSA plans are prohibited from offering prescription drug coverage. If an MSA member wants prescription drug coverage, the member must enroll in a stand-alone PDP.
- If a beneficiary enrolls in an MA plan that includes Part D prescription drug coverage (an MA-PD plan), the beneficiary can only receive Part D drug coverage through that plan.
- If a beneficiary enrolls in an MA plan that is an HMO or PPO plan that does not include Part D coverage, the beneficiary cannot join a stand-alone Prescription Drug Plan (PDP). If the beneficiary wants to remain enrolled with the organization offering their MA plan, they must choose an MA-PD offered by the organization.
    - Enrollees in certain Employer/Union retiree group plans may have different options.

36. MA & Prescription Drugs – Example

Ms. Foley is enrolled in WeCare HMO's ruby plan, which does not include prescription drug coverage. She asks her agent about enrolling in a PDP because she likes WeCare HMO but wants drug coverage. Her agent advises her that to remain with WeCare HMO and receive drug coverage, she must enroll in WeCare's diamond plan, which is an MA-PD plan. She cannot enroll in a PDP if she is enrolled in WeCare HMO.

37. Title Page – Other types of Medicare Health Plans

38. Other Types of Medicare Health Plans

There are other types of Medicare health plans, which are NOT Part C or Medicare Advantage plans. The other types of Medicare health plans include:

- Medicare Cost Plans
- Programs of All-Inclusive Care for the Elderly (PACE) plans
- Medicare-Medicaid Plans (MMPs)
- Other Demonstration Plans
  - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

39. Medicare Cost Plans

Medicare Cost Plans are Medicare health plans that are not Medicare Advantage (Part C) plans and are not Original Medicare.

Cost plan enrollees can choose to receive Medicare-covered services:

- Under the plan's benefits by going to plan network providers
  - The plan's cost-sharing applies when the enrollee gets services from network providers.
- Under Original Medicare by going to non-network providers.
  - Original Medicare cost-sharing applies when the enrollee gets services from non-network providers. This amount is generally higher than the plan cost-sharing.

Medicare Cost Plans:

- may offer Part D prescription drug coverage as an optional benefit but are not required to do so.
- may offer other optional supplemental benefits.
- are available only in certain areas in the United States. In 2024 they were offered in 11 states including some counties in Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin, and Wyoming.

An individual may enroll in a cost plan and a PDP.

- This applies regardless of whether the cost plan offers Part D coverage.

The following individuals are eligible to enroll in a Medicare cost plan:

- Those with Medicare Parts A and Part B; or
- Those with only Part B. Enrollees with Part B only will not have Part A coverage under the plan unless they purchase it. The plan may adjust the enrollee premium for individuals with Part B only.

Premiums:

Enrollees must pay their Part B premiums and any plan premium.

40. PACE Plans

Programs of All-Inclusive Care for the Elderly (PACE):

- are Medicare plans for frail, elderly beneficiaries certified as needing a nursing home level of care but still living in the community (i.e., not in a nursing home).
- are available in most states but tend to have small service areas, and thus may only be available in a few counties.
- offer an adult day health center, where enrollees can get health care, meals, and other services.
- include comprehensive medical and social service delivery systems using an interdisciplinary team approach in the adult day health center, supplemented by in-home and referral services.

Eligibility for PACE: Participants must be

- age 55 or older.
- reside in the PACE organization's service area.
- be certified as eligible for nursing home care by their state.
- be able to live safely in a community setting at the time of enrollment.

Under a PACE Plan:

- There's no deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.
- Beneficiaries with Medicaid pay no premiums.
- Beneficiaries with only Medicare pay a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Part D (in addition to the Part B premium).

41. Medicare-Medicaid Plans (MMPs)

Medicare-Medicaid Plans (MMPs):

  - are established under demonstration authority; and
  - are available only in certain counties in Rhode Island, South Carolina, Texas, California, Illinois, Massachusetts, Michigan, New York, and Ohio.
- Only certain individuals eligible for both Medicare and Medicaid may enroll in MMPs.
  - Eligibility varies by state.
- MMPs financially integrate and provide both Medicare and Medicaid benefits.
  - In some states, MMPs may offer additional benefits.
- All MMPs include Part D benefits.
- MMPs are NOT Medicare Advantage plans.

42. Title Page-Enrollee Protections Appeals and Grievances

43. Enrollee Protections

Enrollees of a Medicare Advantage plan, Medicare Cost plan, PACE plan, or MMP have a right to:

- file complaints (sometimes called grievances), including complaints about the quality of their care.
- get a decision about health care payment or services, or prescription drug coverage.
- get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

44. Enrollee Protections: Grievances

The grievance process is used for complaints about the operations of a plan or its network providers.

- Enrollees or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for the delivery of health care.
- An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at https://www.medicare.gov/MedicareComplaintForm/home.aspx.
- Plans must also provide a link to the Medicare.gov website where the enrollee can enter a complaint.

Example:

Mr. Russell went to an orthopedic surgeon after being referred by his primary care doctor. He sat in the waiting room for two hours after his appointment time before being called in to see the doctor. He called his MA plan to complain. The customer service representative told him that she could take his complaint, or he could file it through the plan's website. He opted to file it through the plan website. The plan investigated his complaint and responded to Mr. Russell.

45. Enrollee Protections: Coverage Decisions

- Coverage decisions are determinations made by a Medicare health plan concerning whether medical care or prescription drugs are covered, how they are covered, and the beneficiary's share of the cost.
- Examples of times when an enrollee may need a coverage decision include:
    - To get prior authorization for a provider to furnish a service.
    - To obtain payment for certain items or services, such as the type or level of services the enrollee thinks should be furnished.
    - To obtain payment for urgently needed services the enrollee received when they were temporarily out of the area.
    - To continue a service that the enrollee believes is medically necessary.
    - To obtain payment for a prescription drug.
    - To ask for an exception from a plan's formulary requirements (including step therapy requirements) or tiering structure for prescription drugs.

- An enrollee has a right to ask for prior authorization even when it is not required to find out if a service will be covered by the plan.

46. Enrollee Protections: Appeals

The appeals process is used to ask for a review of the plan's coverage or payment decisions.

- If an enrollee is not satisfied with the coverage decision, they, or in some cases their physician, can appeal the decision.
    - Physicians can appeal prior authorization denials on behalf of their patients.
- An appeal is a formal way to ask the plan to review or change a coverage decision.
- An appeal can also be filed if:
    - an enrollee believes a Medicare health plan did not pay for or authorize a service that should be covered. Where the plan did not pay, the enrollee must be financially liable in order to appeal.
    - an enrollee believes an authorized service such as a hospitalization or home health care is ending too soon.
    - an enrollee believes a plan has not authorized or paid for a Part D prescription drug that should be covered.

47. Enrollee Protections: Appeals

- Medicare health plans must provide enrollees with a written description of the appeal process.
- Medicare health plans offering a Part D benefit must:
    - provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision about coverage of a drug.
    - require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination concerning a drug.

48. Sources of Additional Information

- Medicare & You Handbook
  https://www.medicare.gov/medicare-and-you
- Detailed information on Medicare Advantage plan requirements
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending
- Information on Medicare Advantage enrollment and eligibility
  https://www.cms.gov/files/document/cy-2024-ma-enrollment-and-disenrollment-guidance.pdf