



2024 PRODUCER HANDBOOK

AZ Blue Medicare Advantage, Supplement,
& Blue MedicareRx Plans



An Independent Licensee of the Blue Cross Blue Shield Association

We're Here to Help



Our Broker Support team is here to help you deliver best-in-class service to your clients. Our team members can answer application questions, look up contracted providers, check on supply orders, and more!



BROKER SUPPORT:

480-389-2712

BCBSBRKsupport@azblue.com

8 a.m. to 4:30 p.m., Monday – Friday



BUSINESS DEVELOPMENT EXECUTIVE:

Nemecio Cid

602-206-2204

Nemecio.Cid@azblue.com

Cynthia Bates

520-400-1732

Cynthia.Bates@azblue.com

Kenya Vega Nunez

480-340-7640

Kenya.Veganunez@azblue.com

Melissa Makin

Medicare, Market Sales Manager

520-437-7277

Melissa.Makin@azblue.com

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Welcome!

Thank you for partnering with Blue Cross® Blue Shield® of Arizona (AZ Blue) and sharing your expertise and experience to help Medicare beneficiaries understand and enroll in the Medicare plan option that meets their needs.

We encourage you to review the updated handbook which includes important information about our growing Medicare plan portfolio. In addition to relevant information about all the plans, you'll also find answers to many of the common questions your clients may have.

Your success is important to us, so you'll also find information about enrollment, producer contracting, commission information, and more.

USING THIS HANDBOOK

Inside you'll find answers to common questions that may come up as you prepare to interact with beneficiaries in the marketplace. It contains important compliance information about selling and advertising Blue MedicareRx, Blue Medicare Supplement, and the AZ Blue Medicare Advantage plans, enrolling beneficiaries in the plans, general Medicare costs, producer contracting, commission information, and more.

The information in this handbook is not a complete description of benefits. Contact Blue Cross Blue Shield of Arizona for more information. Limitations, copayments, and restrictions may apply. The formulary and pharmacy network may change at any time. Benefits, premiums, and/or copayments/coinsurance may change on January 1 each year.

Blue Cross® Blue Shield® of Arizona is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in Blue Cross® Blue Shield® of Arizona plans depends on contract renewal.

BCBSAZ Medicare Advantage is now a wholly owned subsidiary of BCBSAZ and its products will be marketed as BCBSAZ products for 2024. Enrollment in Blue Cross Blue Shield of Arizona depends on contract renewal.

Explore Medicare Solutions from Blue

You already know that many people find it challenging to choose the right Medicare plan. With so many choices available, your clients turn to you for help in navigating the details that make one plan different from the next. Blue offers something for everyone. We're excited to share all that's new.

STARTING AT
\$0
PREMIUM

Medicare Advantage Plans

All-in-one medical and prescription drug plans with HMO and PPO options

All Plans

- \$0 or low monthly premium
- No Specialist referral required for HMO plans
- Maximum out-of-pocket costs starting as low as \$2,500
- \$0 primary care provider visits
- \$0 tier-one and tier-six prescription drugs
- In-network coverage on PPO plans when traveling to numerous states
- Feature a variety of provider networks
- 100-day extended supply for tier-one and tier-two drugs
- No-cost fitness membership and home exercise kits

Select Plans

- Chiropractic, acupuncture, and therapeutic massage services
- \$15-\$75 quarterly over-the-counter allowance
- \$0 routine hearing exam with free upgrade to rechargeable hearing aids
- \$0 routine eye exam with hardware allowance
- \$10 copay preventive dental cleanings



Medicare Supplement Plans

Covers most costs not paid by Original Medicare

Senior Security plan: Choice of any U.S. doctor who accepts Medicare

Senior Preferred plan: Choose from more than 31,000 providers in the Arizona network

- Monthly premiums starting as low as \$100
- 5% savings for two or more members living in the same household
- Early enrollment discounts
- No preexisting condition waiting periods
- No referrals are needed to see a specialist
- Routine hearing exam and hearing aid services, and free upgrade to rechargeable hearing aids
- No-cost fitness membership and home exercise kits



Prescription Drug Plans

Easy and convenient prescription plans

- Choice of two plans
- Access to over 50,000 pharmacies nationwide
- Generic and brand-name drugs
- \$0 tier-one drugs and \$3-\$5 tier-two drugs
- 90-day supply of medications available for tier-one through tier-four drugs through retail or mail order. Tier-five drugs do not qualify



MAPD PRODUCT INFORMATION

Medicare Advantage Plans for Everyone

Blue Best Life Plus (HMO) Available in Maricopa County & Pinal County	Blue Best Life Classic (HMO) Available in Maricopa County & Pinal County	BlueJourney (PPO) Available in Maricopa County & Pima County
Medicare Advantage Prescription Drug Plan Coverage with access to doctors, specialists, and hospitals including Banner.	\$0 monthly premium plan featuring access to doctors, specialists and hospitals, including Banner.	Best plan for active adults on the go, with flexibility to choose from a wide selection of doctors in Maricopa and Pima counties. Plus, coverage if your clients live in Arizona part time or travel out of state.*
Who is this plan for? • I need preventive care and want to pay a low monthly premium for more protection including dental coverage. • I want a large network of doctors and hospitals to choose from and prefer Banner Health Network. • I have ongoing health conditions, and want to reduce potential out-of-pocket costs when I need care.	Who is this plan for? • I need preventive care with no monthly premium. • I am willing to pay higher fixed copays and out-of-pocket costs for a large network of doctors and hospitals to choose from and prefer Banner (Maricopa County members)/Northwest Hospital (Pima County members).	Who is this plan for? • I am new to Medicare from an employer-sponsored plan. • I am active and in the prime of my life. • I want a larger network of doctors and hospitals to choose from. • I like to travel and want access to coverage throughout the U.S. *Arizona must be the member's state of residence.

BCBSAZ offers BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Medicare Advantage HMO plans.



Maricopa County and Pinal County Plan Highlights (1 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-006)	Blue Best Life Plus (HMO) (H0302-001)
Service Area (County)	Maricopa/Pinal	Maricopa/Pinal
Monthly Premium	\$0	\$45
Maximum Out-of-Pocket Limit	\$2,900	\$2,500
Primary Care Provider (PCP)	\$0 copay	\$0 copay
Specialist	\$20 copay	\$25 copay
Routine Eye Exam	\$0 copay	\$0 copay
Eyewear	\$200 annual single-purchase allowance	\$200 annual single-purchase allowance
Annual Physical Exam	\$0 copay	\$0 copay
Inpatient Hospital	\$225 (days 1-6)	\$225 (days 1-6)
Routine Labs	\$0 copay	\$0 copay
X-rays	\$20 copay	\$10 copay
Physical Therapy Services	\$20 copay	\$10 copay
Meals	14 meals post discharge	14 meals post discharge
Over-the-Counter (OTC) Products	\$75 quarterly allowance	\$50 quarterly allowance
Ambulance Services – Ground Transportation	\$275 copay	\$275 copay
Emergency Care	\$125 copay	\$125 copay
Urgent Care Services	\$25 copay	\$25 copay



Maricopa County and Pinal County Plan Highlights (2 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-006)	Blue Best Life Plus (HMO) (H0302-001)
Service Area (County)	Maricopa/Pinal	Maricopa/Pinal
Worldwide Emergency Care and Transportation/ Urgent Care Coverage	\$120 copay \$30,000 combined lifetime maximum	\$100 copay \$60,000 combined lifetime maximum
Gym Membership: SilverSneakers®²	Included	Included
Routine Hearing Exam + Hearing Aid¹	\$0 copay + hearing aid copay (\$699-\$999 per ear, per year) Rechargeable hearing aid upgrade included.	\$0 copay + hearing aid copay (\$699-\$999 per ear, per year) Rechargeable hearing aid upgrade included.
Dental - Preventive/Comprehensive (Non-Medicare covered)	\$10 office visit copay Select Preventive Services: 2x/year Comprehensive Services: 50% coinsurance \$2,000 benefit maximum	\$10 office visit copay Select Preventive Services: 2x/year Comprehensive Services: 50% coinsurance \$3,000 benefit maximum
Acupuncture (Medicare Covered)	\$30	\$30
Chiropractic (Medicare Covered)	\$20	\$20
Acupuncture, Chiropractic, and Therapeutic Massage¹ (Non-Medicare Covered)	\$15 (30 combined visits)	\$15 (30 combined visits)

SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent and separate company contracted with Blue Cross Blue Shield of Arizona (BCBSAZ) to provide health and wellness services to BCBSAZ members. The SilverSneakers program is not an insurance policy and does not provide insurance coverage.

Maricopa County and Pinal County Plan Highlights (3 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-006)	Blue Best Life Plus (HMO) (H0302-001)
	Maricopa/Pinal	Maricopa/Pinal
Prescription Drug Coverage		
Prescription Deductible	No deductible	
Retail Cost Sharing	One-month supply	
Tier 1: Preferred Generic	\$0 copay	\$0 copay
Tier 2: Generic	\$9 copay	\$9 copay
Tier 3: Preferred Brand	\$47 copay	\$47 copay
Tier 4: Non-Preferred Drug	\$100 copay	\$100 copay
Tier 5: Specialty Drugs	33% coinsurance	33% coinsurance
Tier 6: Select Care Drugs	\$0 copay	\$0 copay
Retail and Mail-Order Cost Sharing	Extended-day supply	
Tier 1: Preferred Generic	\$0 copay (100-day supply)	\$0 copay (100-day supply)
Tier 2: Generic	\$9 copay (100-day supply)	\$9 copay (100-day supply)
Tier 3: Preferred Brand	\$141 copay (90-day supply)	\$141 copay (90-day supply)
Tier 4: Non-Preferred Drug	\$300 copay (90-day supply)	\$300 copay (90-day supply)
Tier 5: Specialty Drug	Not available	Not available
Tier 6: Select Care Drugs	\$0 copay	\$0 copay

This is only a summary of benefits. Please refer to the Evidence of Coverage for a full description of benefits.

BCBSAZ is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in BCBSAZ plans depends on contract renewal.

Please contact Member Services at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331, TTY: 711. Hours are 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31.



Maricopa County and Pima County Plan Highlights (1 of 3)

Plan Benefit	BlueJourney (PPO) (H5140-001) BlueJourney (PPO) (H5140-002)	
Service Area (County)	Maricopa and Pima Counties	
Monthly Premium	\$60	
Deductible (medical)	\$0	
	In-Network	Out-of-Network
Maximum Out-of-Pocket Limit	\$3,600	\$5,400 (In-Network (INN) Out of Network (OON))
Primary Care Provider (PCP)	\$0 copay	\$30 copay
Specialist	\$30 copay	\$50 copay
Routine Eye Exam ^{1*}	\$0 copay	40% coinsurance
Eyewear ^{1*}	\$200 annual single-purchase allowance	\$200 annual single-purchase allowance
Annual Physical Exams	\$0 copay	40% coinsurance
Inpatient Hospital	\$250 (days 1-6)	40% coinsurance
Routine Labs	\$0 copay	40% coinsurance
X-rays	\$0 copay	40% coinsurance
Physical Therapy Services	\$40 copay	40% coinsurance
Meals	14 meals post discharge	14 meals post discharge
Over-the-Counter (OTC) Products	\$50 quarterly allowance	Not applicable
Ambulance Services – Ground Transportation	\$275 copay	\$275 copay
Emergency Care	\$125 copay	\$125 copay
Urgent-Care Services	\$35 copay	\$35 copay
Worldwide Emergency Care and Transportation/Urgent Care Coverage	Not applicable	\$100 copay, \$60,000 combined lifetime maximum
Travel Benefit ²	Included	Included
Gym Membership: SilverSneakers	Included	Included

Maricopa County and Pima County Plan Highlights (2 of 3)

Plan Benefit	BlueJourney (PPO) (H5140-001) BlueJourney (PPO) (H5140-002)	
Service Area (County)	Maricopa and Pima Counties	
Routine Hearing Exam + Hearing Aid ^{1*}	\$0 copay + hearing aid copay (\$ 699-\$999 per ear, per year). Rechargeable hearing aid upgrade included.	40% coinsurance + hearing aid copay (\$ 699-\$999 per ear, per year). Rechargeable hearing aid upgrade included.
Dental - Preventive/Comprehensive (Non-Medicare Covered)	\$10 office visit copay Select Preventive Services: 2x/year Comprehensive Services: 50% coinsurance \$3,000 benefit maximum (INN and OON)	\$10 office visit copay Select Preventive Services: 2x/year Comprehensive Services: 50% coinsurance \$3,000 benefit maximum (INN and OON)
Acupuncture (Medicare Covered)	\$30	40% coinsurance
Chiropractic (Medicare Covered)	\$20	40% coinsurance
Acupuncture, Chiropractic, and Therapeutic Massage ¹ (Non-Medicare Covered)	\$15 (30 combined visits)	\$15 (30 combined visits)



Maricopa County and Pima County Plan Highlights (3 of 3)

Plan Benefit	BlueJourney (PPO) (H5140-001) BlueJourney (PPO) (H5140-002)
	Maricopa and Pima Counties
Prescription Drug Coverage	
Prescription Deductible	No deductible
Retail Cost Sharing	One-month supply
Tier 1: Preferred Generic	\$0 copay
Tier 2: Generic	\$9 copay
Tier 3: Preferred Brand	\$47 copay
Tier 4: Non-Preferred Drug	\$100 copay
Tier 5: Specialty	33% coinsurance
Tier 6: Select Care Drugs	\$0 copay
Retail and Mail-Order Cost Sharing	Extended-day supply
Tier 1: Preferred Generic	\$0 copay (100-day supply)
Tier 2: Generic	\$9 copay (100-day supply)
Tier 3: Preferred Brand	\$141 copay (90-day supply)
Tier 4: Non-Preferred Drug	\$300 copay (90-day supply)
Tier 5: Specialty	Not available
Tier 6: Select Care Drugs	\$0 copay

This is a summary of benefits. Please refer to the Evidence of Coverage for a full description of benefits.

*Network provider must be used for in- and out-of-network benefits. Benefits received out of network are subject to any in-network benefit maximums, limitations, and/or exclusions.

†Only available outside of Arizona when utilizing Blue network providers.

‡Out-of-network/non-contracted providers are under no obligation to treat BCBSAZ members, except in emergency situations. Please call your customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

BCBSAZ is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in BCBSAZ plans depends on contract renewal.

Pima County Plan Highlights (1 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-008)
Service Area (County)	Pima
Monthly Premium	\$0
Maximum Out-of-Pocket Limit	\$2,900
Primary Care Provider (PCP)	\$0 copay
Specialist	\$25 copay
Routine Eye Exam ¹	\$0 copay
Eyewear ¹	\$200 annual single-purchase allowance
Annual Physical Exam	\$0 copay
Inpatient Hospital	\$250 (days 1-6)
Routine Labs	\$0 copay
X-rays	\$20 copay
Physical Therapy Services	\$20 copay
Meals	14 meals post discharge
Over-the-Counter (OTC) Products	\$50 quarterly allowance

Pima County Plan Highlights (2 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-008)
Service Area (County)	Pima
Ambulance Services – Ground Transportation	\$275 copay
Emergency Care	\$125 copay
Urgent-Care Services	\$35 copay
Gym Membership: SilverSneakers²	Included
Routine Hearing Exam + Hearing Aid¹	\$0 copay + hearing aid copay (\$699-\$999 per ear, per year). Rechargeable hearing aid upgrade included.
Acupuncture (Medicare Covered)	\$30
Chiropractic (Medicare Covered)	\$20
Acupuncture, Chiropractic, and Therapeutic Massage¹ (Non-Medicare Covered)	Not covered

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Pima County Plan Highlights (3 of 3)

Plan Benefit	Blue Best Life Classic (HMO) (H0302-008)
	Pima
Prescription Drug Coverage	
Prescription Deductible	No deductible
Retail Cost Sharing	One-month supply
Tier 1: Preferred Generic	\$0 copay
Tier 2: Generic	\$9 copay
Tier 3: Preferred Brand	\$47 copay
Tier 4: Non-Preferred Drug	\$100 copay
Tier 5: Specialty	33% coinsurance
Tier 6: Select Care Drugs	\$0 copay
Retail and Mail-Order Cost Sharing	Extended-day supply
Tier 1: Preferred Generic	\$0 copay (100-day supply)
Tier 2: Generic	\$9 copay (100-day supply)
Tier 3: Preferred Brand	\$141 (90-day supply)
Tier 4: Non-Preferred Brand	\$300 (90-day supply)
Tier 5: Specialty	Not available
Tier 6: Select Care Drugs	\$0 copay

This is only a summary of benefits. Please refer to the Evidence of Coverage for a full description of benefits.

¹Through network provider and preferred brand.

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BCBSAZ offers BluePathway HMO and BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Medicare Advantage Standard, Classic, and Plus HMO plans.

Medicare Advantage Tips

Member ID Card

Members receive a separate mailing after their enrollment is confirmed. Please note: If members switch from one AZ Blue Medicare Advantage plan to another AZ Blue Medicare Advantage plan, they will receive a new member ID card with an updated prefix (the three letters that precede the numbers). To ensure prompt handling of claims, members will need to present their new member ID card to providers and pharmacies so they can update their records.

Low Income Subsidy (LIS)

To view premium amounts for those who qualify or may qualify for extra help, please visit azblue.com/Medicare.

Mail-Order Pharmacy

OptumRx®

1-800-356-3477

www.optumrx.com

MAPD Observation Services

Members classified/placed as “observation” through the emergency room (ER) are considered *outpatient*, and are subject to the ER copay, plus all applicable coinsurance/copays for any labs, tests, X-rays, etc., rendered while in the emergency room. Per our Evidence of Coverage (EOC): “Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an ‘outpatient.’”

For provider lookup, please see our Provider/Pharmacy Directories. Providers: azblue.com/findMedicareDoc. Pharmacy Directory: azblue.com/MAPDDocs and azblue.com/PDPDocs.

Medicare Advantage Tips

Diabetic Monitoring Supplies

For blood glucose monitors, test strips, lancets, and lancet devices, we highly recommend that members use supplies offered by our preferred manufacturers, LifeScan and Roche (listed below). The copay is \$0 for these supplies. Using non-preferred manufacturers will require the member to have to pay 20% coinsurance.

- LifeScan and Roche Supplies





MEDICARE SUPPLEMENT PRODUCT INFORMATION

Medicare Supplement Plans: Senior Security and Senior Preferred

Applicants are eligible to enroll in any BCBSAZ Medicare Supplement plan if they:

- Do not have End Stage Renal Disease (does not apply to clients with a guaranteed issue right)
- Are 65 years of age or older, and
- Are enrolled in Medicare Parts A and B

Those under 65 and on disability are not eligible.

All Senior Security and Senior Preferred plans include:

- Specialist visits without a referral
- No preexisting condition waiting period
- Access to the ScriptSave® program, which provides competitive savings on all brand-name and generic drugs allowed by Medicare; available at retail pharmacies and by mail*

*ScriptSave is a drug discount card program operated by Medical Security Card Company (MSCC), an independent and separate company contracted with BCBSAZ to make the ScriptSave program available to BCBSAZ members. ScriptSave is not insurance coverage. MSCC does not provide BCBSAZ products or services and is solely responsible for ScriptSave services.



Senior Security Eligibility

To be eligible to enroll in Senior Security, members must reside in Arizona and be eligible for Medicare Part A and enrolled in Part B. Members have the flexibility to see any Medicare-participating doctor in the U.S., with no service-area restrictions.

Senior Security Plans

Senior Security	Plan A	Plan C	Plan D	Plan F	Plan G	Plan N ¹
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	✓	✓	✓	✓	✓	✓ copays apply
Medicare Part B coinsurance or copay	✓	✓	✓	✓	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copay	✓	✓	✓	✓	✓	✓
Skilled nursing facility care coinsurance	✗	✓	✓	✓	✓	✓
2023 Part A (\$1,600)	✗	✓	✓	✓	✓	✓
2023 Part B (\$226)	✗	✓	✗	✓	✗	✗
Part B excess charges	✗	✗	✗	✓	✓	✗
Foreign travel emergency (up to plan limits)	✗	✓	✓	✓	✓	✓

¹ Plan N pays 100% of the Part B coinsurance, except up to a \$20 office visit copay and up to a \$50 copay for emergency room visits. The copay of up to \$50 is waived if the insured is admitted to any hospital, and the emergency room visit is covered as a Medicare Part A expense.

Change to Senior Preferred Eligibility

Residents of the following counties are eligible for Senior Preferred (Medicare Select): Apache, Cochise, Coconino, Maricopa, Mohave, Pima, Pinal, and Santa Cruz. Plan members must use doctors and hospitals in the Arizona-based Senior Preferred provider network, which includes more than 31,000 providers. The newest provider directory is available at azblue.com/FindMedicareDoc.

BCBSAZ Senior Preferred Plans

Senior Preferred*	Plan C	Plan D	Plan G	Plan N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	✓	✓	✓	✓ copays apply
Medicare Part B coinsurance or copay	✓	✓	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓
Part A hospice care coinsurance or copay	✓	✓	✓	✓
Skilled nursing facility care coinsurance	✓	✓	✓	✓
2023 Part A (\$1,600)	✓	✓	✓	✓
2023 Part B (\$226)	✓	✗	✗	✗
Part B excess charges	✗	✗	✓	✗
Foreign travel emergency (up to plan limits)	✓	✓	✓	✓

*For Senior Preferred, non-emergency services are only covered if the member uses a network provider. Senior Preferred plans are available only for applicants residing in Apache, Cochise, Coconino, Maricopa, Mohave, Pima, Pinal, or Santa Cruz counties.

The best time to buy a Medigap (Medicare Supplement) policy is during the Medigap Open Enrollment Period. This six-month period begins on the first day of the month in which the member is 65 or older and enrolled in Part B. After this enrollment period, the member may not be able to buy a Medigap policy. If the member is able to buy one, it may cost more.

Senior Preferred Hospitals

Maricopa County (35)

Abrazo Arrowhead Campus	Banner Del E. Webb Medical Center	Dignity Health Arizona General Hospital	HonorHealth Scottsdale Thompson Peak Medical Center
Abrazo Central Campus	Banner Desert Medical Center	Dignity Health St. Joseph's Hospital and Medical Center	Mercy Gilbert Medical Center
Abrazo Scottsdale Campus	Banner Estrella Medical Center	Dignity Health St. Joseph's Westgate Medical Center	Mountain Vista Medical Center
Abrazo West Campus	Banner Gateway Medical Center	HonorHealth Deer Valley Medical Center	Oasis Hospital
Arizona Orthopedic and Surgical Specialty Hospital	Banner Heart Hospital	HonorHealth Greenbaum Surgical Specialty Hospital	Tempe St. Luke's Hospital
Arizona General Hospital – Laveen	Banner Thunderbird Medical Center	HonorHealth John C. Lincoln Medical Center	The CORE Institute Specialty Hospital
Arizona Spine & Joint Hospital	Banner University Medical Center Phoenix	HonorHealth Piper Surgery Center	Valleywise Health Medical Center
Banner Baywood Medical Center	Carl T. Hayden VA Medical Center	HonorHealth Scottsdale Osborn Medical Center	Wickenburg Community Center
Banner Boswell Medical Center	Chandler Regional Medical Center	HonorHealth Scottsdale Shea Medical Center	

Pima County (7)

Carondelet St. Joseph's Hospital – Tucson	
Carondelet St. Mary's Hospital – Tucson	Sells Indian Hospital
Northwest Medical Center – Tucson	Southern Arizona VA Health Care System
Oro Valley Hospital Oro Valley	Tucson Medical Center – Tucson

Pinal County (3)

Banner Casa Grande Medical Center – Casa Grande
Banner Goldfield Medical Center – Apache Junction
Banner Ironwood Medical Center – San Tan Valley

Coconino County (3)

Flagstaff Medical Center
Page Hospital
Tuba City Regional Health Care

Medicare Supplement Transfer Rules

Plans effective January 1, 2018, and forward – NEW BLOCK

In the left column, find the plan the member is currently enrolled in and read from left to right to find the transfer options. Cells shaded dark gray indicate the member's current plan.

Current Plan	Senior Security						Senior Preferred			
Senior Security	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N	Plan C*	Plan D	Plan G	Plan N
Plan A		‡	‡	‡	‡	‡	‡	‡	‡	‡
Plan C*	T		T	‡	T	T	T	T	T	T
Plan D	T	‡		‡	‡	T	‡	T	T	T
Plan F*	T	T	T		T	T	T	T	T	T
Plan G	T	T	T	‡		T	T	T	T	T
Plan N	T	‡	‡	‡	‡		‡	‡	‡	T
Senior Preferred	Plan A	Plan C*	Plan D	Plan F*	Plan G	Plan N	Plan C*	Plan D	Plan G	Plan N
Plan C*	T _s	T _s	T _s	‡	‡	T _s		T	T	T
Plan D	T _s	T _s	T _s	‡	‡	T _s	‡		T	T
Plan G	T _s	T _s	T _s	T _s	T _s	T _s	T	T		T
Plan N	T _s	T _s	T _s	‡	‡	T _s	‡	‡	‡	

T Transfer allowed. When transferring, the member's current rate and applicable early enrollment discount go with them. For example, currently enrolled with a standard rate, any allowable transfer is given with standard rate. If a member is enrolled with BlueValueSM rate and has an early enrollment discount for age 65, any allowable transfer is given with BlueValue rate with age 65 discount.

T_s Transfer allowed. Standard rate will apply to the new policy. Applicable early enrollment discount will be applied. To retain the BlueValue rate, the member must go through underwriting.

‡ Transfer NOT allowed. New application is required.

*Due to a change in federal law, Medicare Supplement plans C and F will be available only to people who were eligible for Medicare before January 1, 2020.

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Medicare Supplement Transfer Rules

Plans effective June 1, 2010, through December 1, 2017 – OLD BLOCK

In the left column, find the plan the member is currently enrolled in and read from left to right to find the transfer options. Cells shaded dark gray indicate the member's current plan.

Current Plan	Senior Security					Senior Preferred	
Senior Security	Plan A	Plan C	Plan F	Plan G	Plan N	Plan C	Plan N
Plan A		‡	‡	‡	‡	‡	‡
Plan C	T		‡	T	T	T	T
Plan F	T	T		T	T	T	T
Plan G	T	T	‡		T	T	T
Plan N	T	‡	‡	‡		‡	T
Senior Preferred	Plan A	Plan C	Plan F	Plan G	Plan N	Plan C	Plan N
Plan C	T _s	T _s	‡	‡	T _s		T
Plan N	T _s	T _s	‡	‡	T _s	‡	

T Transfer allowed. When transferring, the member's current rate and applicable early enrollment discount go with them. For example, currently enrolled with a standard rate, any allowable transfer is given with standard rate. If a member is enrolled with BlueValue rate and has an early enrollment discount for age 65, any allowable transfer is given with the BlueValue rate with age 65 discount.

T_s Transfer allowed. Standard rate will apply to the new policy. Applicable early enrollment discount will be applied. To keep the BlueValue rate, the member must go through underwriting.

‡ Transfer NOT allowed. New application is required.

To move to 2018 NEW block of business, or retain the BlueValue rate when switching plans, all members must go through underwriting.

Medicare Supplement Transfer Rules

Grandfathered 1990 plans

Except for Senior Preferred, plans sold **prior to June 2010 do NOT** have transfer options and are not allowed to have effective dates after May 31, 2010. For grandfathered Senior Preferred members who want to switch to Senior Security, please refer to the grid below.

Current Grandfathered Plan	Available June 2010 Senior Security Transfer			
Senior Preferred	Plan A	Plan C	Plan F	Plan N
Plan C	T	T	†	T
Plan H	T	T	T	T

Please make sure the Senior Preferred grandfathered member understands the following: Because different underwriting rules apply to the June 2010 plans, grandfathered Senior Preferred members requesting transfer must fill out the health questionnaire in order to determine the new rate. The Senior Preferred member has a guaranteed right to transfer to a comparable or lesser Senior Security policy. The health questionnaire is required for rating purposes only, not for denying coverage.

Internal and producer use only. Not for public disclosure.

Medicare Supplement Helpful Tips – MACRA

What are your clients' Medicare Supplement plan options?

Here's a look at how MACRA (Medicare Access and CHIP Reauthorization Act of 2015) affects your Medicare clients' plan choices. If you have any questions about eligibility, please contact your business development executive.



Newly Eligible for Medicare during 2020 and later

- Not age 65 on January 1, 2020
- Eligible for Medicare **after** January 1, 2020
- **Cannot** purchase a plan C or F
- Will likely find the most comprehensive coverage in plan D or G

For people who qualify for Medicare because of a disability or ESRD on or after January 1, 2020, the restrictions under MACRA apply.



Eligible for Medicare *before* 2020

- Is 65 or older before January 1, 2020*
- Eligible for Medicare **before** January 1, 2020
- **Can** purchase a plan C or F
- May eventually find it more cost effective to switch to plan D or G

*Non-newly eligibles may be under age 65 on 1/1/2020 if they become eligible for Medicare due to disability or end-stage renal disease before that date. Source: Wing-Heier, Lori. "Implementation Guidance for MACRA (Medicare Access and CHIP Reauthorization Act of 2015) Revisions to Medigap Model Regulation." National Association of Insurance Commissioners, 8 Feb. 2018.



PDP PRODUCT INFORMATION



2024 Blue MedicareRx plans offer choice and flexibility.

Plan Benefit	Blue MedicareRx Value (PDP)	Blue MedicareRx Enhanced (PDP)
Monthly Premium	\$57.20	\$158.60
Annual Deductible	\$545	\$0
Retail Cost Sharing	One-month supply	
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
Tier 2 (Generic)	\$3 copay	\$3 copay
Tier 3 (Preferred Brand)	25% of the cost	20% of the cost
Tier 4 (Non-Preferred Drugs)	33% of the cost	45% of the cost
Tier 5 (Specialty)	25% of the cost	33% of the cost
Coverage Gap – amount your client pays for a 30-day supply after their total yearly covered prescription drug cost reaches \$5,030 ¹		
• Generic Drugs	25% of the cost	25% of the cost
• Brand-name Drugs	25% of the cost	25% of the cost
Catastrophic Coverage – Cost sharing for covered Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage beginning in CY2024		
Pharmacies in the Preferred Network (nationwide)	Over 50,000	Over 50,000
Mail Order (90-day supply)	Tier 1-4: 3x 30-day supply cost or the usual coinsurance	Tier 1-4: 2.5x 30-day supply cost or the usual coinsurance

¹Your clients' "total drug costs" means the total amount they have paid for covered drugs plus what the plan has paid for the calendar year. This does not include the plan premium they pay.

Contracting

Our contracting guidelines change, so for the most current information, please contact Broker Services at bcbsbrksupport@azblue.com or call **480-389-2712**.

Contract Submission

Contracts are completed electronically through our online Contracting and Certification platform. You will be required to upload your Errors & Omissions certificate. Before a contract is processed, you must complete and pass the applicable certification(s). To gain access to the platform or if you have any questions regarding this process please reach out to medsalescon@azblue.com.

Contract Termination

Contract terminations may occur for the following reasons:

- AZ State Health Insurance License has expired
- Failure to complete the applicable certification(s)(renewals)
- No Error & Omissions Insurance Coverage
- A breach in the contract
- Compliance allegation(s) where the producer was found at fault

Other Contract Procedures

BCBSAZ prefers producers to contract through our Field Marketing Organizations for our Medicare Advantage and Supplement Products. Producers who are interested in the Blue MedicareRx, PDP, will need to contact BCBSAZ directly. To learn more about contracting with BCBSAZ, please contact Medicare Sales at medsalescon@azblue.com.

Field Marketing Organizations

Bishop and Brown 6814 N. Oracle Rd. #220, Tucson, AZ 85704 520-572-4270	Western Asset Protection 4550 E. Bell Rd. #118, Phoenix, AZ 85032 602-955-5353	Pinnacle Financial Services 65 W. Street Rd., Suite A-101, Warminster, PA 18974 1-800-772-6881
Senior Market Advisors 2716 S. 6th Ave., Tucson, AZ 85713 520-760-6223	Fidelis 1757 E. Baseline Rd., Ste. 102, Gilbert, AZ 85233 480-712-8699	Berwick Insurance Group 4576 E. Camp Lowell Dr., Tucson, AZ 85717 520-745-2300
Applied General Agency 1040 N. Tustin Ave., Anaheim, CA 92807 1-800-498-6880	Health Plans USA 7440 E. Pinnacle Peak Rd., Suite 142, Scottsdale AZ 85255 480-691-2500	Spark Advisors 8 Spruce St #33W New York, NY 10038 855-949-2097

Contracting ... continued

Commissions

Our commissions plan compensates you for your efforts in selling Blue MedicareRx, BCBSAZ Medicare Supplements, and/or BCBSAZ Medicare Advantage plans. Payments will be made in compliance with CMS requirements and with the rates set in your contract.

Producers who are under a Field Marketing Organization and have an issue with commission should contact the Field Marketing Organization first. Producers who are under a Field Marketing Organization do not get paid directly by Blue Cross Blue Shield of Arizona.

BCBSAZ may refuse to pay commission to those Producers identified as having issues with enrollment application submission timeliness or who submit enrollment application through the prohibited US Postal Service "regular mail" or who send applications to a non-contracted vendor. After-the-fact agent of record considerations will not impact this action step.

You can view monthly commission statements through the Broker Portal at **azblue.com/brokersandconsultants**. For commission questions, call **602-864-4262** ext. **1172** or email brkfin@azblue.com.

For more about CMS regulatory requirements for broker compensation, follow this Medicare Marketing Guidelines link on **CMS.gov** and search for agent/broker compensation: **<http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>**



2023 – 2024 BCBSAZ Medicare Supplement Plan Commission Schedule – Individual Producers

Subproducer Commissions

- BCBSAZ will pay compensation only to a Subproducer who is in compliance with all requirements of the Addendum and provisions of the Agreement applicable to individual producers.
- BCBSAZ will pay commissions, in accordance with the commission schedule below, only after a member is both enrolled in the Medicare Supplement Product and reflected in the BCBSAZ enrollment system as “processed.”
- If a member voluntarily or involuntarily disenrolls after the original effective date, BCBSAZ will recoup compensation paid for months in which the member was not enrolled.
- In this exhibit, “PMPM” means per member per month.

2023 MEDICARE SUPPLEMENT COMMISSION SCHEDULE

Number of years in which an individual is enrolled in Individual Medicare Supplement Product with BCBSAZ	Year 1 of Medicare Supplement enrollment with BCBSAZ	Years 2+ of Medicare Supplement enrollment with BCBSAZ
Medigap Open Enrollment Period, Underwritten Applications, and Guaranteed Issue Applications	\$380 paid in advance for the first year when the enrollment is processed	\$20.83 PMPM

Parameters for New Commissions

- New commissions are for applications with effective dates 6/1/2023 forward.
- Applies to New to Blue Medicare Supplement plans only.
- Applications for members transferring from a BCBSAZ Group, Individual, & Family Plan (IFP), or Medicare Advantage plan are also eligible for the new commission schedule.
- Current (policies effective prior to 5/1/22) BCBSAZ Medicare Supplement plan changes to another BCBSAZ Medicare Supplement plan are NOT eligible for the new commissions.
- New to Blue is defined as a Medicare beneficiary who has not been a BCBSAZ Medicare Supplement member within the last 365 days.

CONFIDENTIAL AND PROPRIETARY INFORMATION OF BCBSAZ

BCBSAZ MAY UPDATE THIS COMPENSATION SCHEDULE AS SPECIFIED IN SECTION 11.3 OF THE GENERAL AGENT AGREEMENT

FOR PRODUCER USE ONLY. NOT FOR USE WITH THE GENERAL PUBLIC.

2024 BCBSAZ Medicare Advantage Plan Commission Schedule – Individual Producers

2024 BLUE CROSS BLUE SHIELD OF ARIZONA MEDICARE ADVANTAGE PLAN COMMISSION SCHEDULE PRODUCERS/SUBPRODUCERS		
Year One Initial year in which Enrollee is enrolled in a Medicare Advantage Prescription Drug Plan (MAPD)	Year One Existing Medicare MAPD Enrollee new to BCBSAZ MAPD Plan	Years Two through Lifetime of the policy in which the Enrollee is enrolled in BCBSAZ MAPD Plan
\$611 One-Time Fee	\$306 One-Time Fee	\$25.50 Per Member Per Month

Eligibility for Commission

BCBSAZ will pay commission for Medicare Advantage Plan sales only to producers who: (1) have a contract with BCBSAZ that expressly authorizes the broker to sell Medicare Advantage Plans; (2) have a valid Arizona license authorizing the producer to sell health insurance products in the state of Arizona and an Errors and Omissions Policy acceptable to BCBSAZ; (3) are identified by the enrollee as the Broker of Record; and (4) have completed annual training and testing on BCBSAZ and CMS policies, procedures, and requirements and have received a score of no less than 85% on the test of Medicare rules and regulations.

Year One Commission Amount

For the first year in which the Medicare Advantage enrollee is enrolled in any BCBSAZ Medicare Advantage Plan, BCBSAZ will pay a one-time commission of \$611. BCBSAZ will make the commission payment upon CMS’s notification that CMS has accepted the Medicare Advantage enrollee, i.e., CMS has recorded in its records that the customer is enrolled in BCBSAZ’s Medicare Advantage Plan.

Year One Existing MAPD Member

For the first year in which an existing Medicare Advantage member is enrolled in any BCBSAZ Medicare Advantage Plan, BCBSAZ will pay a one-time commission of \$306. BCBSAZ will make the commission payment upon CMS’s notification that CMS has confirmed the enrollment of the Medicare Advantage enrollee, i.e., CMS has recorded in its records that the customer is enrolled in BCBSAZ’s Medicare Advantage Plan.

Years Two through Lifetime of Policy Amount

BCBSAZ will pay commissions of \$25.50 per member per month for the lifetime of the policy in which the Medicare Advantage member has been enrolled.

2024 BCBSAZ Medicare Advantage Plan Commission Schedule – Individual Producers

Date BCBSAZ will pay Commission

BCBSAZ will pay commissions, in accordance with the then in effect commission payment schedule, for years two through lifetime of policy amount on the date BCBSAZ has received both the application and CMS's notification that CMS has confirmed the enrollment of the enrollee.

Year One Disenrollments

If an enrollee voluntarily or involuntarily disenrolls with an effective disenrollment date within the first three months after the original effective date and CMS notifies BCBSAZ that CMS deems the disenrollment a valid rapid disenrollment, BCBSAZ will charge back to the broker 100% of the commission BCBSAZ paid.

If an enrollee voluntarily or involuntarily disenrolls with an effective disenrollment date during months 4 through 12 after the original effective date of YEAR ONE, BCBSAZ will charge back the broker for commission paid for months in which the member was not enrolled.

Years Two through Lifetime of Policy Disenrollments

If an enrollee voluntarily or involuntarily disenrolls with an effective disenrollment date during months 4 through 12 after the original effective date for years two through lifetime, BCBSAZ will charge back the broker for all commissions paid during months in which the member was not enrolled.

Examples:

Enrollee's Medicare Advantage enrollment is effective on 1/1/2024. BCBSAZ paid broker \$25.50 per member per month payment for Year Two commission. Enrollee disenrolls with a disenrollment effective date of 6/30/2024. The disenrollment effective date (6/30/2024) is not within the first three months of the enrollee's original effective date (1/1/2024), so BCBSAZ does not charge back 100% of the commission. The disenrollment effective date occurs during the 6th month after the original effective date therefore, BCBSAZ will charge back half of the commission to recoup for July through December.

Enrollee's Medicare Advantage enrollment is effective on 1/1/2024. BCBSAZ paid broker \$611 one-time fee for Year One commission. Enrollee disenrolls with a disenrollment effective date of 6/30/2024. The disenrollment effective date (6/30/2024) is not within the first three months of the enrollee's original effective date (1/1/2024), so BCBSAZ does not charge back 100% of the commission. The disenrollment effective date occurs during the 6th month after the original effective date therefore, BCBSAZ takes back half of the one-time commission to recoup for July through December.

2024 BCBSAZ Prescription Drug Plan Commission Schedule – Individual Producers

2024 BLUE CROSS BLUE SHIELD OF ARIZONA MEDICARE ADVANTAGE PLAN COMMISSION SCHEDULE PRODUCERS/SUBPRODUCERS

Year One Initial year in which Enrollee is enrolled in Prescription Drug Plan (PDP)	Year One Existing Medicare PDP Enrollee new to BCBSAZ PDP Plan	Years Two Through Lifetime of the policy in which the Enrollee is enrolled in BCBSAZ MAPD Plan
\$100 One-Time Fee	\$50 One-Time Fee	\$4.16 Per Member Per Month

Eligibility for Commission

BCBSAZ will pay commission for PDP products only to producers who: (1) have a contract with BCBSAZ that expressly authorizes the broker to sell PDP; (2) have a valid Arizona license authorizing the producer to sell health insurance products in the state of Arizona and an Errors and Omissions Policy acceptable to BCBSAZ; (3) are identified by the enrollee as the Broker of Record; and (4) have completed annual training and testing on BCBSAZ and CMS policies, procedures, and requirements and have received a score of no less than 85% on the exam titled “Blue MedicareRx Individual Product Exam.”

Year One Commission Amount

For the first year in which the PDP enrollee is enrolled in any PDP product, BCBSAZ will pay a one-time commission of \$100 per PDP contract. BCBSAZ will make the commission payment upon CMS’s notification that CMS has accepted the PDP enrollee, i.e., CMS has recorded in its records that the customer is enrolled in BCBSAZ’s PDP Plan.

Year One Existing PDP Member

For the first year in which an existing PDP member is enrolled in any BCBSAZ Medicare PDP Plan, BCBSAZ will pay a one-time commission of \$50. BCBSAZ will make the commission payment upon CMS’s notification that CMS has accepted the PDP enrollee, i.e., CMS has recorded in its records that the customer is enrolled in BCBSAZ’s PDP Plan.

Years Two through Lifetime Commission Amount

BCBSAZ will pay commissions of \$4.16 per member per month for years two through the lifetime of the policy in which the PDP member has been enrolled.

Date BCBSAZ will pay Commission

BCBSAZ will pay commissions, in accordance with the then in effect commission payment schedule, for year one and for years two through lifetime on the date BCBSAZ has received both the application and CMS’s notification that CMS has confirmed the enrollment of the enrollee.

Preparing to Sell

Producers must be certified and appointed before they can sell Blue MedicareRx, BCBSAZ Medicare Advantage, or Supplement Plans. Once approved, producers will receive notification from their Field Marketing Organization of their effective date and writing number. For Blue MedicareRx and/or direct contracting, producers will receive notification directly from BCBSAZ.

Annual Training

Producers must train, certify, and test annually on Medicare rules, regulations, and on details specific to Blue MedicareRx and/or the BCBSAZ Medicare Advantage plans in order to receive commission or commission renewal payments. This requirement applies even if a producer is no longer actively selling the products but wishes to continue to receive commission.

Selling and Advertising

Producers are to follow CMS guidelines when selling and enrolling members in Blue MedicareRx and/or the BCBSAZ Medicare Advantage plans. This will help ensure that the producer receives credit for the sale. Producers may reference the latest version of the CMS Medicare Communication and Marketing Guidelines at – <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines>.

Scope of Appointment Form

Before meeting with a beneficiary, producers are to complete a scope of appointment (SOA) form. Here are a few requirements for producers:

- SOA must be obtained 48 hours prior to the scheduled appointment with the beneficiary. CMS does provide two exceptions to the 48-hour rule: (1) if beneficiary is approaching the end of a valid enrollment period (last 4 days of the election period), or (2) walk-ins – beneficiaries who walk into the plan's office, agent's office, or kiosk.
- Use of an approved SOA carrier form or either the Blue Cross Blue Shield of Arizona SOA form available on the enrollment website or the broker portal at **azblue.com**.
- Whether or not an application is taken, CMS requires that producers keep a copy of the SOA form for 10 years – plus the current year – and make it available to CMS or Blue Cross Blue Shield of Arizona upon request.

Producer Communication and Marketing Requirements

The Centers for Medicare & Medicaid Services (CMS) have revised their requirements for Producers who represent Medicare Advantage and/or Part D plans. Producers are to follow the requirements in 42 CFR §§ 423.2274, 422.2274, 423.2264, and 422.2264. Representation includes selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

Preparing to Sell...continued

Producers must record all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety. The recorded calls are to be kept for 10 years – plus the current year – and be made available to CMS or Blue Cross Blue Shield of Arizona upon request.

Producers are to provide the standardized Third Party Marketing Organization (TPMO) disclaimer statement: “If the TPMO does not sell for all MAOs in the service area the disclaimer consists of the statement: We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact **Medicare.gov, 1-800-MEDICARE**, or your local State Health Insurance Program to get information on all of your options.

If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: “Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact **Medicare.gov, 1-800-MEDICARE**, or your local State Health Insurance Program for help with plan choices.” The disclaimer must be:

- Used by any TPMO, as defined under 42 § 423.2260 and 42 § 422.2260, that sells plans on behalf of more than one Part D sponsor and/or MA organization unless the TPMO sells all commercially available Part D plans in a given service area.
- Verbally conveyed within the first minute of a sales call.
- Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
- Prominently displayed on TPMO websites.
- Included in any TPMO marketing materials, including print materials and television advertising.

Beneficiaries enrolled by producers understand the product, including the rules applicable under the plan.

Applies to producers conducting lead generating activities for the MA organization or Part D Sponsor:

- Disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided:
 - Verbally when communicating with beneficiary through telephone;
 - In writing when communicating with a beneficiary through mail or other paper; and
 - Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.
- Disclose to the beneficiary, when applicable, that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.

Preparing to Sell...continued

Information about sales events is not required to be filed with CMS. However, Producers who would like to conduct a sales event related to Blue Cross Blue Shield of Arizona are required to complete and submit a Sales Event Reporting form to the Broker Support Team. CMS can request this information from Blue Cross Blue Shield of Arizona at any time.

Sales/marketing events must include the following two disclaimers on all event advertising:

1. A producer will be present with information and applications.
2. For accommodation of persons with special needs at sales meetings, please contact the Broker Support Team at **480-389-2712** or **711** for the TTY line , **TTY: 711**.

For questions about sales events, including requirements, advertising, timing, etc., please contact the Broker Support Team at **480-389-2712**.

Canceling or Changing Your Sales Event

Producers who need to cancel or change the date of a scheduled sales event should notify Blue Cross Blue Shield of Arizona as soon as possible – ideally more than 48 hours prior to the originally scheduled date and time of the event. The Sales Event Change/Cancellation Reporting Form should be completed and submitted to Broker Support. Please contact Broker Support at **480-389-2712** with any questions. Producers should also make a good faith effort to notify attendees of the cancellation or have someone onsite for 15 minutes to inform them of the cancellation, unless it is impractical to do so.

A note about educational events

Educational events are events designed to inform Medicare beneficiaries about MA, prescription drug, or other Medicare programs. They do not steer or attempt to steer potential enrollees toward a specific plan or limited number of plans. Educational events are held in public venues and do not extend to in-home or one-on-one settings. You may provide education at a sales or marketing event, but you may not market or sell at an educational event.

There are two types of educational events, each with its own set of guidelines:

Prospective Enrollee

Educational events for prospective enrollees may not include any sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. This includes the distribution of any material with plan-specific information (including plan-specific premiums, copayments, or contact information). Educational events must be explicitly advertised as “educational,” otherwise they will be considered by CMS as sales/marketing events.

Enrollee Only

If you hold enrollee-only educational events, you may not conduct enrollment or sales activities during these events. However, you may discuss plan-specific premiums and/or benefits and distribute plan-specific materials to enrollees. Educational events must be explicitly advertised as “educational,” otherwise they will be considered by CMS as sales/marketing events.

BCBSAZ Medicare Advantage, Blue MedicareRx, and Medicare Supplement Application Submission

A signed Medicare enrollment application must reach Blue Cross Blue Shield of Arizona within two calendar days of when you receive it from a beneficiary (this is usually two calendar days from the producer signature date). This allows Enrollment enough time to process the application and send it to CMS for approval within the required timeframe.

Let's back up a bit and talk about getting to the point where you're ready to submit a Blue MedicareRx, BCBSAZ Medicare Advantage, or Medicare Supplement enrollment application. Once you and the beneficiary determine the suitability of a new plan, the beneficiary's eligibility for that plan, and that a valid enrollment period exists, you're ready to begin the enrollment process.

In this section of the handbook, we'll review each of the following steps:

1. Completion of enrollment request
2. Receipt of enrollment request by Blue Cross Blue Shield of Arizona
3. Determination of enrollment eligibility
4. Submission (accretion) to CMS
5. CMS approval
6. Confirmation of enrollment notice

Enrollment Step 1:

Completion of Enrollment Request

The preferred method for **BCBSAZ Medicare Advantage, BCBSAZ Medicare Supplement, and Blue MedicareRx** application submission is electronic. Access to the BCBSAZ producer online enrollment platform via Connecture will be granted within 48 hours after the contract(s) has been processed. An email will be sent to the producer with their login credentials to complete their registration. Producers can submit online enrollments via the BCBSAZ Producer Enrollment Portal, <https://azblue2.destinationrx.com/PC/Agent>. You may also submit applications using the following methods:

- Complete a paper enrollment form and submit it online via <https://azblue2.destinationrx.com/PC/Agent>
- Complete a paper enrollment form and submit it by fax or overnight delivery

Reminder: Make sure you put your Producer/Broker of Record number on all enrollment requests mailed or left with an enrollee to ensure receipt of commission.

Enrollment

Online Enrollment

Producers are strongly encouraged to enroll beneficiaries online whenever possible. Online enrollment reduces errors and delays – and is easy to do.

For a valid online enrollment to occur, beneficiaries (or their authorized representative) **must**:

- Be present at the time of the online enrollment or give you permission to submit their enrollment online by checking the authorization box on the paper enrollment request
- Be able to view the online application throughout the enrollment process
- Receive a paper copy of the confirmation statement upon submission of the online enrollment
- Receive a separate email confirmation of the online enrollment, if requested

If you are assisting beneficiaries in completing paper enrollment forms and plan to submit their enrollments online, there is a section on the application that must be completed by the beneficiary. The beneficiary must check the authorization box below their signature to authorize you to submit their paper application online. You must keep the paper enrollment form on file for 11 years.

Paper applications that are being submitted online should be submitted immediately but must be submitted no later than two calendar days after the producer signature date the application.

Producers **are not allowed** to submit an online enrollment with information provided by the beneficiary over the phone.

Telephonic Enrollment

- Plan Sponsors may accept telephonic enrollment requests via an incoming telephone call from a beneficiary to complete an enrollment.
- Telephonic enrollment request must be effectuated entirely by the beneficiary or his/her authorized representative.
- No other producers, brokers, or agents can be physically present or present on the phone at the time of this call.
- Producers, brokers, and agents may be on the call with the pre-enrollment call center and the member to give identifier information, but then must disconnect from the call prior to the enrollment of the member.
- Telephonic enrollments must be recorded using a CMS-compliant script to ensure that beneficiaries:
 - Understand they are being recorded.
 - If the TPMO does not sell for all MAOs in the service area the disclaimer consists of the statement: “We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact **Medicare.gov, 1-800-MEDICARE**, or your local State Health Insurance Program to get information on all of your options.”

Please note that if you send the beneficiary to the call center, you will lose the Agent of Record on the policy.

The phone number for Blue MedicareRx telephonic enrollment is **1-888-264-1568**. The phone number for the BCBSAZ Medicare Advantage plans’ telephonic enrollment is **1-888-274-0367**. The phone number for Blue Medicare Supplement plans’ telephonic enrollment is **1-888-264-1733**.

Enrollment ... continued

If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: “Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact **Medicare.gov**, **1-800-MEDICARE**, or your local State Health Insurance Program for help with plan choices.”

- Are attesting to the accuracy of required elements.
- Understand they are completing an enrollment.
- Are attesting to their intent to enroll.

Paper Enrollment

If you receive a paper enrollment form, you cannot submit the form by regular mail. It must be faxed or sent by overnight delivery and must be submitted immediately after you sign it.

- Fax Blue MedicareRx enrollment forms to **1-800-368-6023**.
- Fax BCBSAZ Medicare Advantage enrollment forms to **602-544-5623**.
- Fax BCBSAZ Medicare Supplement enrollment forms to **602-864-4041**.

Include a cover sheet with the name of the beneficiary(ies), number of enrollment forms included in the transmittal, and your name and contact information. You must keep the fax confirmation and the paper enrollment form for 11 years.

Send Blue MedicareRx enrollment forms by overnight delivery to:

OptumRx
P.O. Box 269029
Weston, FL 33326-9029

Send BCBSAZ Medicare Advantage enrollment forms by overnight delivery to:

Blue Cross of Blue Shield of Arizona
P.O. Box 29234
Phoenix, AZ 85038

Send BCBSAZ Medicare Supplement enrollment forms by overnight delivery to:

Blue Cross Blue Shield of Arizona
P.O. Box 81049
Phoenix, AZ 85069-1049

Premium Payments

Beneficiaries will be able to select a premium payment option when they complete their enrollment. Premium payments should not be submitted with a paper enrollment form. Members will be billed once CMS approves the enrollment and the plan becomes effective.

Enrollment ... continued

Enrollment Step 2:

Acknowledgment of Receipt of Enrollment Request

For all enrollment options, Blue Cross Blue Shield of Arizona is required to contact the beneficiary within 10 calendar days of the application date. In addition to this notice, online enrollees may print a confirmation of their enrollment submission and/or request an email confirmation. Beneficiaries completing paper enrollments must keep a copy of the form.

Application Date

The application date is the date the enrollment request is received by Blue Cross Blue Shield of Arizona, including receipt by a producer. When an enrollment request is not date-stamped, it may impact the effective date of coverage for the beneficiary.

Acknowledgment of Receipt of Enrollment

Once enrollment elections are received, Blue Cross Blue Shield of Arizona has 10 calendar days from the application date to provide the beneficiary with:

- An acknowledgment letter verifying receipt of a complete enrollment request which may be used as proof of coverage until member materials arrive, or
- A telephonic or written request for missing or clarifying information, or
- A written notice that the enrollment was denied based on a determination that the beneficiary was ineligible

Within 15 calendar days of the application receipt date, the beneficiary will receive a verification letter to make sure he or she understands the plan rules.

Common Errors on Enrollment Request

Some of the most common errors that result in incomplete enrollment requests, delayed processing, and/or delayed effective dates, include:

- Not using the beneficiary's legal name as identified by Social Security
- Missing or incorrect date of birth
- Missing, incorrect, or incomplete Medicare Number
 - Must include all letters and numbers
- No plan option selected
- Not listing complete physical or mailing address
- Missing beneficiary signature (or the signature of the authorized representative)
- Election period not identified
- For HMO plans specifically, not selecting a primary care provider (PCP) on the enrollment request (which can lead to enrollment processing delays)

Enrollment ... continued

Enrollment Step 3:

Determination of Enrollment Eligibility

Blue Cross Blue Shield of Arizona will review the enrollment request to verify that the beneficiary meets all CMS eligibility requirements.

Denial of Beneficiary's Enrollment

If a beneficiary's enrollment is denied based on ineligibility, it is often because the beneficiary does not reside in the service area or is not eligible for a valid enrollment period. Other reasons for denial are if the beneficiary does not provide missing information or does not submit clarifying documentation as requested within the required timeframe. Under these circumstances, Blue Cross Blue Shield of Arizona must notify the beneficiary of the denial, including the reason for the denial, within 10 calendar days of this determination. The application can only be denied if the beneficiary does not respond or responds with a confirmation that he or she is ineligible. When an enrollment is denied by Blue Cross Blue Shield of Arizona it means that the enrollment request was not submitted to CMS because Blue Cross Blue Shield of Arizona determined that the enrollment was not valid.

What Can't be Sent to CMS

Enrollment requests with missing or incomplete information cannot be sent to CMS for approval. In this case, the beneficiary will be contacted by phone or in writing within 10 calendar days of the application receipt date to request missing information or clarifying documentation. The beneficiary has 21 calendar days from receipt of the request, or until the end of the month in which the request was received, whichever is later, to supply the missing information. All additional information provided by the beneficiary will be date-stamped as soon as it is received. If the requested information is received within the allowable timeframe, and the enrollment is deemed complete, the plan must forward the enrollment to CMS within seven calendar days. For AEP enrollments, the beneficiary has 21 calendar days from receipt of this request, or until December 7, whichever is later, to provide the requested information. If the information is not provided in that timeframe, the enrollment request is denied, and the beneficiary is notified of the denial.

If an enrollment period cannot be determined on the application, the enrollment request cannot be sent to CMS for approval. The beneficiary must be contacted and Blue Cross Blue Shield of Arizona must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. If the enrollment period is validated, the enrollment request must be submitted to CMS within seven calendar days from the receipt of the application. If the election period is not validated, the enrollment request must be denied within 10 calendar days of the application date.

Enrollment ... continued

Enrollment Step 4:

Submission (Confirmation to CMS)

Submission to CMS is an electronic transaction that occurs once Blue Cross Blue Shield of Arizona determines that the individual is eligible. Blue Cross Blue Shield of Arizona must submit complete enrollment requests to CMS within seven calendar days. The beneficiary can use the acknowledgement letter from Blue Cross Blue Shield of Arizona as proof of coverage until member materials arrive.

Enrollment Step 5:

CMS Confirmation

Once Blue Cross Blue Shield of Arizona determines eligibility, the enrollment is submitted to CMS. CMS then confirms the transaction.

Enrollment Step 6:

Confirmation of Enrollment Notice

Once Blue Cross Blue Shield of Arizona is notified that the beneficiary's enrollment request is approved, member materials are mailed. These materials include a confirmation letter, ID card, and member guide. The confirmation letter issued by the plan notifies the beneficiary of CMS's response and must be mailed within 10 days of CMS's notice to Blue Cross Blue Shield of Arizona.

If CMS rejects the enrollment, Blue Cross Blue Shield of Arizona must also notify the beneficiary of the CMS rejection within 10 calendar days of the notice. The letter will describe the reason that CMS rejected the election request as well as the beneficiary's appeal rights.

Member Guides

Each member guide includes important plan and contact information. Enrollees will be notified that they can find the pharmacy list and provider directory online at azblue.com/Medicare.

Enrollment Submissions for MAPD, PDP, and Medicare Supplement Plans

We highly recommend submitting enrollments using the Online Enrollment Tool for your MAPD and PDP clients. You will receive a confirmation code upon submission, and you will have peace of mind knowing that all enrollment information was received. Most importantly, your application is transferred to our enrollment system and processed in a timely manner.

BCBSAZ Advantage Online Enrollment Form:

<https://azblue2.destinationrx.com/PC/Agent>

BCBSAZ Blue Medicare PDP Online Enrollment Form:

<https://azblue2.destinationrx.com/PC/Agent>

Medicare Supplement Website:

<https://azblue2.destinationrx.com/PC/Agent>



Enrollment Submissions for MAPD, PDP, and Medicare Supplement Plans ... continued

The following are a few compliance tips and enrollment processing reminders to help you safely steer through the selling process:

Submit enrollment applications within 48 hours (two calendar days) of the enrollee signature date.

- Be sure to **review your applications thoroughly before submitting them.** Incomplete or inaccurate information can lead to processing delays.
- Check for these common enrollment errors:
 - Incorrect Medicare ID number
 - Incorrect Medicare Part A and Part B effective dates
 - Incorrect election period
 - Not using the beneficiary's legal name as identified on the Medicare ID card
 - Plan option not selected

If you accidentally submit an online enrollment with incorrect information or the wrong plan year: DO NOT resubmit a new application. Contact our Broker Support team and we will assist in correcting the error.

There is no need to fax any enrollment documentation if you are using the online enrollment tool.

If you are unable to use the online enrollment tool, fax applications to the appropriate fax number:

- **MAPD** applications: **602-544-5623**
- **PDP** applications: **1-800-269-2132**
- **MS** applications: **602-864-4041**

Remember to save a copy of the fax confirmation sheet.

Per CMS, remember that it is your responsibility to keep the original enrollment documentation (application, SOA, and confirmation code or transmission receipt) for 11 years.

Medicare Costs At-a-Glance

Summary of 2023 Medicare Costs

Part A premium

Most people do not pay a monthly premium for Part A. If a member buys Part A, they will pay up to \$506 each month.

If a member has paid Medicare taxes for:

- Less than 30 quarters, the standard Part A premium is \$506
- 30-39 quarters, the standard Part A premium is \$278

Part A hospital inpatient deductible and coinsurance

Member pays:

- \$1,600 deductible for each benefit period
- Days 1-60: \$0 coinsurance for each benefit period
- Days 61-90: \$400 coinsurance per day of each benefit period
- Days 91 and beyond: \$800 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs

Part B premium

The standard Part B premium amount is \$164.90 (or higher depending on a member’s income).

Part B deductible and coinsurance

The Part B deductible is \$226 per year. After the deductible is met, a member typically pays 20% of the Medicare-approved amount for most doctor’s services (including most inpatient hospital services received from a doctor), outpatient therapy, and durable medical equipment.

Part C premium

The Part C monthly premium varies by plan

Part D premium

The Part D monthly premium varies by plan

Medicare Part D 2024 Plan Design

Medicare Part D Stages		
Annual deductible	Some plans may include an annual deductible. Beneficiaries pay this amount before the plan begins to pay its share.	
Initial coverage limit	The initial coverage limit is the combined amounts of the plan's share and the beneficiary's copays and coinsurance, including the deductible.	Initial coverage limit: \$5,030
Coverage gap (also called the donut hole)	The coverage gap begins after the total yearly drug cost (including what the plan paid and what the beneficiary has paid) reaches the initial coverage amount for the plan. Not everyone will enter this stage of the plan.	Beneficiary pays: Generic: 25% Brand name: 25% ...of the plan's contracted rates
Catastrophic coverage	Once the beneficiary's true-out-of-pocket (TrOOP)* costs reach \$8,000 , the beneficiary leaves the coverage gap.	Beneficiary pays nothing: Cost Sharing 0%
Part C premium	The Part C monthly premium varies by plan	The initial coverage limit is the combined amounts of the plan's share and the beneficiary's copays and coinsurance, including the deductible.
Part D premium	The Part D monthly premium varies by plan	The initial coverage limit is the combined amounts of the plan's share and the beneficiary's copays and coinsurance, including the deductible.

*TrOOP does not include the amount the plan has paid or plan premium the beneficiary pays.

Costs in the Coverage Gap

During the coverage gap (also called the donut hole) there is a temporary limit on what a drug plan will cover. Most Medicare drug plans have a coverage gap, but not everyone will enter this stage.

The coverage gap begins after a member and the plan have spent a certain amount on covered drugs. For 2024, the coverage gap stage is reached once a member and the plan have spent **\$5,030** on covered drugs. This amount may change year over year.

Members who get financial assistance with Part D costs through the Extra Help program won't enter the coverage gap.

Brand-name and Generic Drugs in the Coverage Gap

Once a member reaches the coverage gap in 2024, the beneficiary pays **25%** for all generic drugs and no more than **25%** for brand-name drugs.

The coverage gap ends when the total out-of-pocket costs reach **\$8,000**. The member's cost is commonly referred to as true out-of-pocket costs, or TrOOP. Some medications are covered during the coverage gap stage.

Refer to the prescription drug formulary for details.

Catastrophic Coverage Stage

Beneficiaries will not pay coinsurance or copay amounts for the remainder of the year.

Getting Out of the Coverage Gap

What Counts?

- A member's annual deductible, coinsurance, and copayments
- A member's discount on brand-name drugs in the coverage gap
- What a member pays in the coverage gap

What Does Not Count?

- A member's Blue MedicareRx or AZ Blue Medicare Advantage plan premium
- Pharmacy dispensing fees
- A member's costs for drugs not covered under the plan

More Savings for Care When Members Need It

All Medicare Advantage plans include even more ways to save and stay healthy:



Nurse On Call – Talk to a nurse anytime, day or night, 365 days a year, at no cost



TruHearing – Savings on hearing aids, hearing aid batteries, and hearing exams



SilverSneakers – No-cost fitness facility membership and home exercise kits

Other wellness resources available to our MA members:



Blue Medicare Health RewardsSM – Earn rewards for healthy behaviors and preventive screenings (MAPD only)



OTC allowance – Quarterly allowance to buy over-the-counter health-related products (MAPD only). A preloaded card with a quarterly allowance that can be used at participating retail locations or through the phone-in/mail-in/online provider Blue Cross Blue Shield of Arizona has contracted for this benefit. Unused amounts will not roll over to the following month.

Contact Information

BROKER SUPPORT – ALL MEDICARE PRODUCTS

Broker Support Line: (480) 389-2712
Email: BCBSBRKSUPPORT@azblue.com
Hours of Operation: 8:00 a.m. – 4:30 p.m., Monday – Friday, Local Time

BROKER SUPPLY ORDERS – ALL MEDICARE PRODUCTS

Email: BCBSBRKSUPPORT@azblue.com
Broker Support Line: (480) 389-2712

BROKER COMMISSION QUESTIONS – ALL MEDICARE PRODUCTS

Commission Team (602) 864-4262 Option 1
Email: BRKFIN@azblue.com

MEDICARE SUPPLEMENT

Pre-Enrollment
<https://azblue2.destinationrx.com/PC/2024/Account/Login>
Application Fax Number: (602) 864-4041

MEMBER SERVICES

(602) 864-4122
Hours of Operation: 8:00 a.m. – 4:30 p.m., Daily, Local Time

MEDICARE BLUE RX – STAND ALONE PDP

Pre-Enrollment
<https://azblue2.destinationrx.com/PC/2024/Account/Login>
Application Fax Number: (800) 368-6023

Post Enrollment
Broker Support: (480) 389-2712
Hours of Operation: 8:00 a.m. – 4:30 p.m., Monday – Friday, Local Time

MEMBER SERVICES

1-844-883-8524
Hours of Operation: 8:00 a.m. – 8:00 p.m., Daily, Local Time

BLUE MEDICARE ADVANTAGE – MAPD

BROKER RESOURCES

Pre-Enrollment
<https://azblue2.destinationrx.com/PC/2024/Account/Login>
Application Fax Number: (602) 544-5623
Provider Search Tool: azblue.com/FindMedicareDoc

MEMBER SERVICES

(800) 446-8331
Hours of Operation: 8:00 a.m. – 8:00 p.m., Daily, Local Time

BROKER & CERTIFICATION PORTALS

Website: azblue.com

Status on Application – App Tracker Tool
Commission Statements
Book of Business Report

Website: <https://bcbsarizona.pinpointglobal.com/Apps/Medicare/default.aspx/>

BCBSAZ Medicare Product Certifications
Medicare Contracting

WEBSITE TECHNICAL SUPPORT

BROKER PORTAL PASSWORD RESETS

Phone: (602) 864-4844
Email: esolutions@azblue.com

CERTIFICATION PORTAL

Email: Medicarehelp@pinpointglobal.com
Phone: 1 (866) 649-3701

YOUR MEDICARE SALES TEAM

Nemecio Cid - Business Development Executive
Cell: (602) 206-2204
Office: (602) 916-8513
Email: Nemecio.Cid@azblue.com

Cynthia Bates - Business Development Executive
Cell: (520) 400-1732
Office (520) 745-7353
Email: Cynthia.Bates@azblue.com

Kenya Vega Nunez - Business Development Executive
Cell: (480) 340-7640
Office: (602) 916-8567
Email: Kenya.Veganunez@azblue.com

Melissa Makin - **Medicare, Market Sales Manager**
Cell: (520) 437-7277
Office: (602) 864-5617
Email: Melissa.Makin@azblue.com

Medicare: (800) 633-4227

Medicare's Website: www.medicare.gov

Medicaid/AHCCCS: (602) 417-4000

State Health Insurance Assistance Programs: (800) 432-4040

Social Security Administration/Extra Help: (800) 772-1213

NOTES

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BCBSAZ is contracted with Medicare to offer HMO and PPO Medicare Advantage plans and PDP plans. Enrollment in BCBSAZ plans depends on contract renewal. BCBSAZ offers BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Medicare Advantage Standard, Classic, and Plus HMO plans. If your client enrolls in a Senior Security or Senior Preferred plan at age 65 through 72, they will receive an early-enrollment discount on their rate. The early-enrollment discount is reduced annually through the age of 76. The change in discount occurs in the next month's bill after clients' birthday. When their discount no longer applies, they will be charged the BlueValue or Standard rate assigned to their Senior Security or Senior Preferred plan. The best time to buy a Medigap (Medicare Supplement) policy is during your clients' Medigap Open Enrollment Period. This six-month period begins on the first day of the month in which your client is 65 or older and enrolled in Part B. After this enrollment period, they may not be able to buy a Medigap policy. If they're able to buy one, it may cost more. Routine eye exam and hearing aid benefits available through participating providers.

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All other companies referenced are separate, independent companies contracted with Blue Cross Blue Shield of Arizona (BCBSAZ) to provide hearing, dental, vision, and fitness benefits. They provide and are solely responsible for certain plan administration and member services. They do not provide BCBSAZ products or services.



An Independent Licensee of the Blue Cross Blue Shield Association

Questions about BCBSAZ Medicare Products?

Contact Broker Support

480-389-2712

BCBSBRKsupport@azblue.com

We're here to help: 8 a.m. to 4:30 p.m., Monday – Friday

Authorized Broker



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