

Plan Recap

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

✓ Fill out this plan recap with your Licensed Sales Representative (if applicable). It will take you through some plan details to help you better understand your new plan.

i **PLAN INFORMATION** Here are some details about your new plan.

My new plan is (circle one): Medicare Advantage plan Medicare Part D plan
Medicare Supplement Insurance (Medigap) plan

The name of my new plan is: _____

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

My plan type: Requires referrals Does not require referrals

My plan will provide: all my Medicare health coverage
 all my Medicare prescription drug coverage

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

Proposed effective date: **MM / DD / YYYY**

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

I must live in the plan's service area, which is: _____.

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

Circle the correct answer:

I **should / should not** have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time. (There is one exception: Medicare Advantage Private Fee-for-Service plans that do not include prescription drug coverage.)

\$ **PREMIUM INFORMATION** What you need to know about paying your monthly plan premium.

My plan has a \$ _____ monthly premium that I must pay to stay in this plan. In addition, I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me.

If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.

TEAR HERE

TEAR HERE

Ready to Enroll



NETWORK INFORMATION Understanding your network is important.

Provider Name	Provider type (PCP/Specialist)	Network (Yes/No)	Referral (Yes/No)

Circle the correct answers: I need to get my care and services from **network / out-of-network** providers. I may have to pay the full cost for any care I get from **network / out-of-network** providers. But if I need emergency care, urgent care, or out-of-area dialysis, it will be covered wherever I need it.



PRESCRIPTION DRUG COVERAGE Know what is covered by your prescription drug plan.

Medication	Tier Level ¹	Has Limits ² (Yes/No)	Deductible (Yes/No)

I have the option to access my plan documents, such as Explanation of Benefits (EOB), electronically.

- I have opted to access documents electronically.
- I have not opted to access documents electronically at this time, but can contact the plan in the future to activate this option.
- I have provided an email address to provide the plan with various ways to reach me regarding important information.
- I do not have an email address; should I get one in the future I can provide it to the plan to provide other ways to reach me with important information.

Contact your Licensed Sales Representative.

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

¹My actual out of pocket costs may vary based on the drug stage I am in, my drug tier level, and the pharmacy I use (retail/mail-order), and if I have Extra Help.

²For medications that have limitations, I may need to contact the plan before I can fill my prescription.