

Frequently Asked Questions: Special Enrollment Period for Medicare Advantage plans

Why is there a special enrollment opportunity?

The Centers for Medicare and Medicaid Services (CMS) is establishing a special enrollment period on a case-by-case basis to address situations where an individual alleges he or she enrolled in a Medicare Advantage plan based on misleading or incorrect information provided by plan material, employees or insurance agents.

What is considered misleading information?

Misleading information is defined as any time a plan member discovers that a promised benefit is, in fact, not available.

What is a Medicare Advantage Plan?

A Medicare Advantage plan is an alternative to standard Medicare coverage that requires additional payment by the beneficiary and offers its services through a private insurance or managed care company. Its coverage often includes prescription drugs. Companies offering Medicare Advantage plans must gain approval from Medicare each year.

Who do I contact with questions about changing plans?

Call 1-800-MEDICARE (1-800-633-4227) and describe how you were misled or given incorrect information.

When do I need to contact Medicare for special enrollment?

You should contact the Centers for Medicare and Medicaid Services (CMS) within a reasonable amount of time from the effective date of enrollment, i.e., within the first three months of plan membership. However, it is possible that you may not discover you were misled until you attempted to use a particular type of plan services; in those instances, CMS may consider older cases for special enrollment.

How do I qualify for special enrollment?

To qualify for special enrollment, it will be helpful to have copies of materials with alleged false or misleading information, if applicable, dates and time of interaction with plan representative and/or agent and names and contact information, before taking the following step:

- Call 1-800-MEDICARE (1-800-633-4227) and describe to the representative how you were misled or given incorrect information by the plan's employees, or insurance agent, including statements that:
 - Indicate the plan is accepted by all providers who accept Medicare.
 - Describe the product as a Medigap plan or supplemental plan that supports Medicare.
 - Offer enrollees the opportunity to switch back to traditional Medicare at any time.

What are examples of circumstances that generally would not be considered to warrant special enrollment?

- The beneficiary simply wants to disenroll from the plan, without any specific allegation about misleading or incorrect information.
- The beneficiary prefers a provider who previously participated in the plan but no longer does so.

What are my coverage options after I qualify for disenrollment?

The Centers for Medicare and Medicaid Services (CMS) will provide all qualified people with Medicare assistance in selecting new Medicare plan options, which may include another Medicare Advantage plan, a Part D plan or Original Medicare.

What happens if I don't qualify for special enrollment?

If the representative for the Centers for Medicare and Medicaid Services (CMS) decides special enrollment is not warranted, he or she will forward your case to the appropriate regional office casework staff for a second review. If the regional caseworker agrees with the denial, he or she will notify you in writing.

Can the Ohio Department of Insurance help me?

Yes. The Department - which operates the Ohio Senior Health Insurance Information Program (OSHIIP) - is the state's lead agency for Medicare information and enrollment assistance. However, Medicare is the point of contact if you want to participate in the special enrollment and select new coverage. You can call OSHIIP at 1-800-686-1578 with any questions about Medicare and to request information.

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