



COMMUNITY FIRST
HEALTH PLANS

Medicare Advantage Plans



Community First Health Plans, Inc. Medicare Advantage Plans 2025 Review

Training & Plan Overview

Topics

- Medicare Basics
- Enrollment and Disenrollment
- Beneficiary Protections
- Communications and Marketing Regulations
- Agent and Broker Compensation
- Medicare Marketing Activities

Medicare Basics

Eligibility Requirements

1. U.S. Citizen or permanent legal resident for 5 years; and
2. Be age 65 or older; or
3. Under age 65 with certain disabilities receiving Social Security Disability Insurance (SSDI) for a minimum of 24 months

Additional Qualifying Medical Criteria:

1. Any Age End Stage Renal Disease requiring dialysis or kidney transplant
2. Any age with Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

Social Security is responsible for determining eligibility and handling enrollment for Medicare.



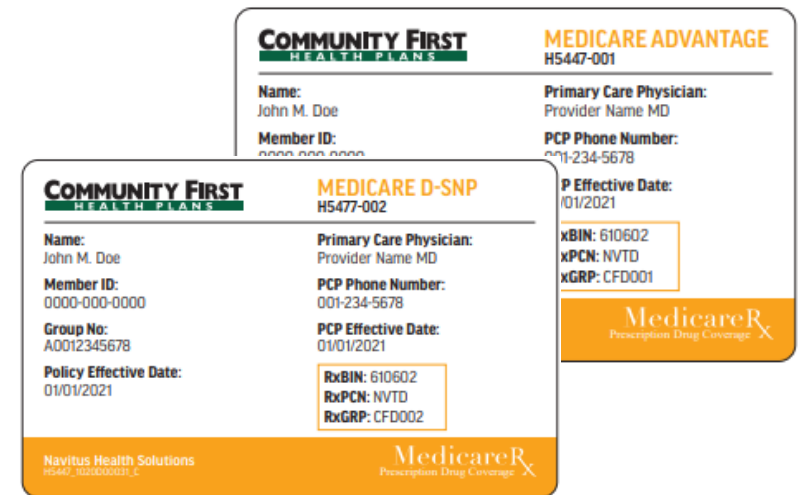
Medicare vs Medicare Advantage

Traditional Medicare

- Includes Medicare Part A (hospital) and Part B (medical)
- No Referral Required (similar to PPO)
- Covered anywhere in the United States
- No dental, vision, or hearing coverage
- No out-of-pocket maximum
- Drug coverage (Part D) must be purchased separately

Medicare Advantage

- “All in one” (includes Part A, Part B, and usually Part D)
- May require referral (similar to HMO)
- Most plans cover dental, vision, & hearing benefits
- Out-of-pocket costs are usually lower
- Must stay within plan’s network of providers



Community First Service Delivery Area

- Alamo Standard HMO Plan covers Bexar County.
- Alamo HMO D-SNP Plan covers 8 counties:
 - Atascosa
 - Bandera
 - Bexar
 - Comal
 - Guadalupe
 - Kendall
 - Medina
 - Wilson



Overview of Plans

Medicare Advantage with Part D Standard Alamo Plan (HMO) combines Part A & B for comprehensive coverage that includes dental, vision and Rx Coverage. You will continue to pay your Part B Premium unless you have extra help.

Medicare Advantage Alamo Dual Eligible Special Needs Plan (HMO D-SNP) is a Dual Eligible Special Needs Plan with benefits designed to provide extra help and support for people who qualify for both Medicaid and Medicare and have special health care needs. You will continue to pay your Part B Premium unless you have extra help.

Community First Medicare Advantage Plans were established in 2021.

Summary of Benefits for Standard Alamo Plan HMO

Premiums and Benefits	In-Network
Monthly Plan Premium	There is no monthly premium for this plan.
Annual Deductible – Part C (Medical)	There is no health deductible for this plan.
Annual Deductible – Part D (Drugs)	There is a \$200 annual deductible for prescription medications.
Maximum Out-of-Pocket Amount (Does not include prescription drugs)	\$3,500 annually for Medicare-covered services you receive from in-network providers.
Inpatient Hospital	\$175 copay per day for days 1-6 \$0 copay per day for days 7-90
Outpatient Hospital	
Ambulatory Surgical Center (ASC)	\$175 copay
Outpatient Hospital, including Surgery	\$175 copay
Outpatient Hospital Observation	\$175 copay
Doctor Visits	
Primary	\$0 copay per visit
Specialists	\$15 copay per visit

Rx Coverage for Standard HMO Alamo Plan

Stage 1: Annual Prescription Deductible	\$0 per year for Tier 1 and Tier 2, and \$200 per year for Tier 3, Tier 4, and Tier 5 Part D Prescription Drugs.					
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	Retail			Mail Order		
	30-Day Supply	60-Day Supply	90-Day Supply	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1: Preferred Generic Drugs	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2: Generic Drugs	\$7 Copay	\$14 Copay	\$17.50 Copay	\$7 Copay	\$14 Copay	\$17.50 Copay
Tier 3: Preferred Brand Drugs	\$30 Copay	\$60 Copay	\$75 Copay	\$30 Copay	\$60 Copay	\$75 Copay
Tier 4: Non-preferred Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier	30% Coinsurance	N/A	N/A	30% Coinsurance	N/A	N/A

The Coverage Gap Stage has been eliminated for 2025.

Stage 3: Catastrophic Coverage - After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,000, the plan pays the full cost of your covered, Part D drugs. You pay nothing.



Summary of Benefits for Alamo D-SNP

Premiums and Benefits	In-Network
Monthly Plan Premium	There is no monthly premium for this plan.
Annual Deductible – Part C (Medical)	There is no health deductible for this plan.
Annual Deductible – Part D (Drugs)	There is a \$590 annual deductible for prescription medications.
Maximum Out-of-Pocket Amount (Does not include prescription drugs)	\$9,150 annually for Medicare-covered services you receive from in-network providers.

Benefits	In-Network
*Inpatient Hospital	\$0 copay for days 1-90
Outpatient Hospital	
*Ambulatory Surgical Center (ASC)	\$0 copay
*Outpatient Hospital, including Surgery	\$0 copay
Outpatient Hospital Observation	\$0 copay
Doctor Visits	
Primary	\$0 copay per visit
Specialists	\$0 copay per visit
Other Health Care Professionals	\$0 copay per visit

Rx Coverage for Alamo D-SNP

Stage 1: Annual Prescription Deductible	\$590 per year for All Tiers Part D Prescription Drugs.					
Stage 2: Initial Coverage (after you pay your deductible, if applicable)	Retail			Mail Order		
	30-Day Supply	60-Day Supply	90-Day Supply	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1: Preferred Generic Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 2: Generic Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 3: Preferred Brand Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 4: Non-preferred Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier	25% Coinsurance	N/A	N/A	25% Coinsurance	N/A	N/A
Stage 3: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,000 , the plan pays the full cost of your covered, Part D drugs. You pay nothing.					



Evidence of Coverage (EOC)

The Evidence of Coverage (EOC) is an overview of the plan. It gives enrollees details about their Medicare health care and prescription drug coverage. It explains how to get coverage for the health care services and prescription drugs they need. Some of the services this document can give details about includes, but is not limited to:

- Urgent Care Services
- Ambulance services
- Emergency Services
- Immunizations
- Dental Services

Value-Added Services

Community First offers the most Value-Added Services to our Medicare Advantage Alamo and D-SNP Members. Members will receive the following Value-Added Services at no cost:

VALUE-ADDED SERVICES
24-Hour Nurse Advice Line
Free YMCA Membership
Pre-loaded payment card to purchase over-the-counter health and wellness products
Post-hospital discharge at-home meal delivery program
Non-emergency transportation to health appointments
Gift card incentives, giveaways, and more for participating in our Health & Wellness Programs

Additional Benefit Plan Vendors

Vision Services:

Envolve Benefit Options – 1-800-334-3937



Dental Services:

Envolve Benefit Options – 1-833-492-0497



Pharmacy:

Navitus Health Solutions – 1-844-268-9789

Over-the-Counter Medications:

NationsBenefits – Contact Community First Member Services at 210-358-6386



Enrollment and Disenrollment

Enrollment And Disenrollment

Types of election periods during which individuals may make enrollment requests.

- **Initial Coverage Election Period (ICEP)** – Period during which an individual is newly eligible for Medicare and can enroll in a Medicare Advantage plan. This is a 7 month period to include the 3 months before an individual meets eligibility and the 3 months after the individual meets eligibility.
- **Annual Enrollment Period (AEP)** – Period when Medicare eligible consumers can make changes to their Medicare coverage to ensure it meets their healthcare needs for the upcoming year. This period runs from October 15th through December 7th.
- **Special Enrollment Period (SEP)** – Period where individuals can make changes to their Medicare Advantage and Medicare drug coverage when certain events happen in their life such as moving and losing other coverage.
- **Medicare Advantage Open Enrollment Period (MA OEP)** – The one opportunity throughout the year to change their Medicare Advantage plan. This period is from January 1st through March 31st. Individuals can switch to another Medicare Advantage plan or switch back to Original Medicare. Changes take effect the 1st of the following month after receipt of the enrollment request.

Beneficiary Protections

Beneficiary Protections

- The first step a member should take to file a grievance is to call Member Services at 210-358-6386 or Toll Free at 1-833-434-2347. If a member needs to take additional action they can refer to the Evidence of Coverage (EOC) for detailed steps.
- Part D Plan (PDP) Enrollments:
 - Enrollees who are enrolled in a MSA or a MA-PFS plan will need to call 1-800-Medicare or submit a written disenrollment request to disenroll as it is not automatic.
 - Enrollees who are enrolled in any MA coordinated care plan (HMO, PPO) or an MA-PFFS plan that includes drug coverage, who is joining a PDP will be automatically disenrolled from their current plan upon enrolling in a PDP.
- Plans may end an enrollee's membership if the following occurs:
 - Enrollee does not stay continuously enrolled in Medicare Part A or Part B.
 - Enrollee is no longer eligible for the plan's SNP category.
 - Enrollee is away from the service area for more than 6 months.

Communications and Marketing Regulations

Communication and Marketing Regulations

- A state insurance department can investigate a sales agent/broker that they suspect is violating Medicare communications and marketing regulations.
- Plan sales agents include those employed by the plan itself and those who are contracted with the plan through direct or downstream contracts. A marketing entity, independent plan agent, and a plan broker can all be considered a plan sales agent.
- Plans can communicate direct plan comparisons provided the information is factual and there is supporting data. Plans may not use ‘scare tactics’ or pressure beneficiaries to enroll.

Agent and Broker Compensation

Agent and Broker Compensation

- Generally, agents/brokers receive an initial payment in the first year of the policy.
- Renewal compensation should be paid up to 50% of the current fair market value (FMV), regardless of whether the member is new to the organization or not.
- Compensation stops if enrollee changes plans that does not use broker/agents.



Medicare Marketing Activities

Medicare Marketing Activities

- Scope of Appointment is needed in all personal or individual face-to-face marketing appointments to include walk-ins and unexpected beneficiaries who wish to attend a pre-scheduled one-on-one meeting with another beneficiary. Scope of Appointment forms are not needed for public marketing event.
- Marketing Activities should not include
 - Meals to potential enrollees regardless of value.
 - Cash or other monetary rebates as an inducement for enrollment.
 - Unsolicited marketing materials to any MA enrollee during the Open Enrollment Period (OEP).

Contact Us

Visit us at: www.medicare.communityfirsthealthplans.com for more information on Schedule of Benefits, Evidence of Coverage, Provider Directory, FAQ's and more.

Member Services Local Number:	210-358-6386
Toll Free Number:	1-833-434-2347
TTY Hearing Impaired (24/7)	711

Hours of Operation: 5 days a week from 8am – 8pm*

*Open 7 days a week from 8am – 8pm October 15th – December 7th

**Voicemail service available afterhours, weekends and holidays