MEDICARE HEALTH INSURANCE

A Primer

Mar 2017 V1.1

Medicare

- What is it?
- What are the parts (A,B,C,D,Medigap)?
- Who can be covered by it?
- What does it cover?
- What does it cost?
- When can it be gotten?

What is it?

Is a health benefits program for U.S. citizens or permanent residents who meet certain work history requirements

Signed into law in 1965.

Administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services

What are the parts of Medicare

- **Original Medicare**
  - **Part A** – Hospital
  - **Part B** – Medical

- **Part C – Medicare Advantage** health plans

- **Part D** – Prescription drug coverage

- **Supplemental / Medigap**

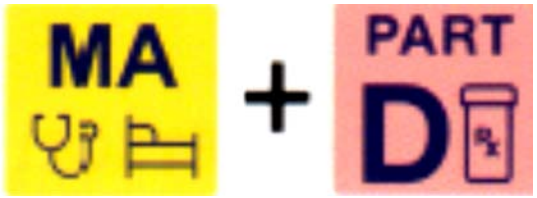
  - Private additional insurance to fill in some gaps in original Medicare

Different Configurations of Medicare

- Original Medicare (Part A + Part B)

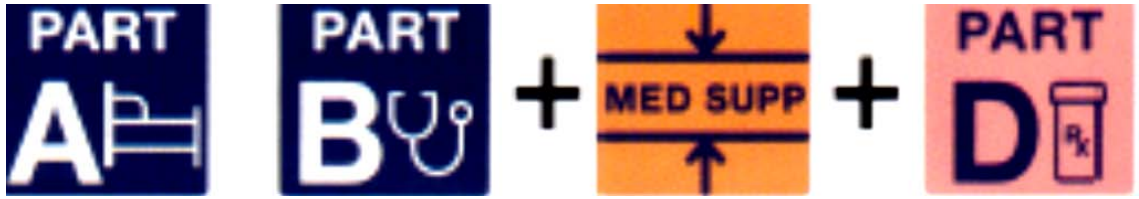
- Medicare Advantage Plans (Part C)

- Medicare Prescription Drug Plans (Part D)

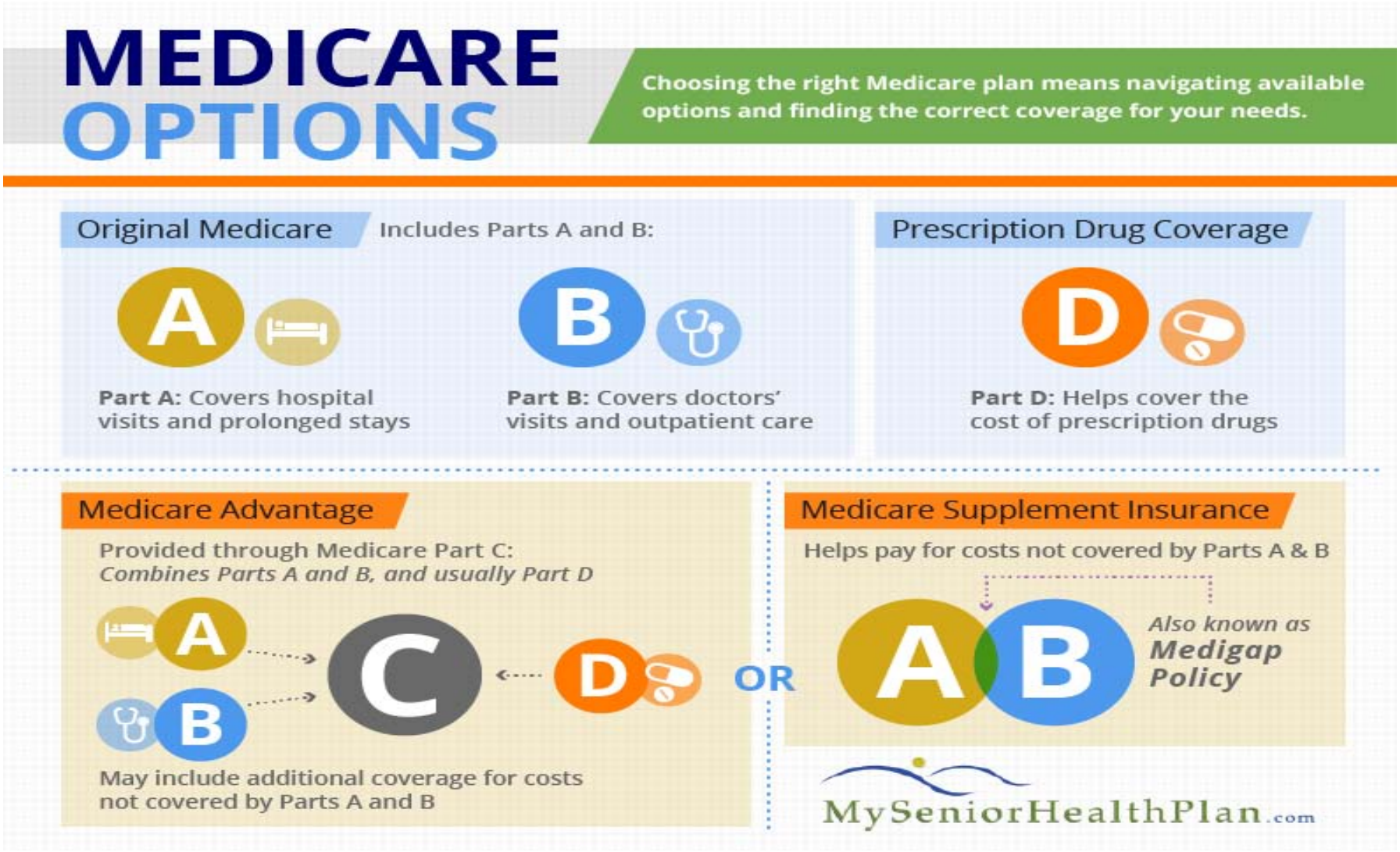


Different Configurations of Medicare

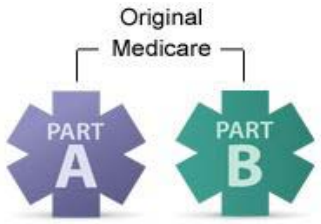
- Original Medicare + Medigap / Supplemental



Different Configurations of Medicare



Original Medicare



- Original Medicare (has **<u>two</u>** Parts – **A** and **B**)
  - **Part A** – **Hospital,** skilled nursing facility, hospice, and home health services
  - **Part B** – **Professional services** such as those provided by a doctor or non-physician professional, outpatient care, and other medical services

Medicare Advantage Plans

- Part C - Medicare Advantage Health Plans

  - *(must cover all Part A and Part B services)*

    - Provided by various approved Private Insurance Companies in different forms
      - Health Maintenance Organizations (HMOs) (some also include Part D)
      - Preferred Provider Organizations (PPOs) (some also include Part D)
      - Private Fee-for-Service Plans (PFFS) (some also include Part D)
      - Special Needs Plans (SNPs) (always include Part D)

Medicare Advantage Plans – cont'd

- **All** Medicare Advantage (MA) plans must:
  - Cover all Part A and Part B benefits of Original Medicare
  - Provide plan cost-sharing actuarially equivalent to cost sharing under Medicare Parts A and B, but may be different for specific services
  - Include an annual maximum out-of-pocket (MOOP) limit on total enrollee cost sharing (deductibles, coinsurance, and copayments) for Part A and Part B services
  - Cover the following services even when provided by non-network providers:
    - emergency services;
    - out-of-area urgently needed services; and
    - out-of-area renal dialysis.

Medicare Advantage Plans – cont'd

- Extra Benefits
  - Medicare Advantage health plans **may** also cover extra benefits not covered by Original Medicare, such as:
    - Vision Services (discounts)
    - Hearing Aids (discounts)
    - Routine Dental Services and/or Dentures (discounts)
    - Routine Transportation to Medical Appointments
    - Chiropractic Services
    - Worldwide Urgently Needed and Emergency Services.

Prescription Drug Plan

- **Part D** – Prescription Drug Coverage
  - Stand-alone Prescription Drug Plan (**PDP**)
    - or
  - Coverage as part of a Medicare Advantage health plan (**MAPD**)

Medigap / Supplemental Coverage

- Medigap insurance:
  - Is sold by approved private insurance companies to fill "gaps" in Original Medicare coverage;
  - Works **only** with Original Medicare;
  - Can **not** be combined with Part C
  - Covers all, or a portion, of Part A and Part B cost sharing (coinsurance, copayments, or deductibles) for beneficiaries in Original Medicare.
  - Some Medigap policies cover benefits not covered by Part A or Part B of Original Medicare, such as extra days of coverage for inpatient hospital care or foreign travel emergency care.

Who is eligible or entitled?

Medicare Entitlement – 

- Most individuals automatically get premium-free Part A coverage if they or a spouse paid Medicare taxes while working for a specified duration of time (last 10 years of work).

- For those individuals who do not automatically qualify for premium-free Part A coverage, the monthly Part A premium depends on an individual's duration of Medicare-covered employment.

- Individuals with disabilities who are under age 65 are automatically enrolled in Part A after they have received Social Security or Railroad Retirement disability benefits for 24 months.

Medicare Entitlement – 

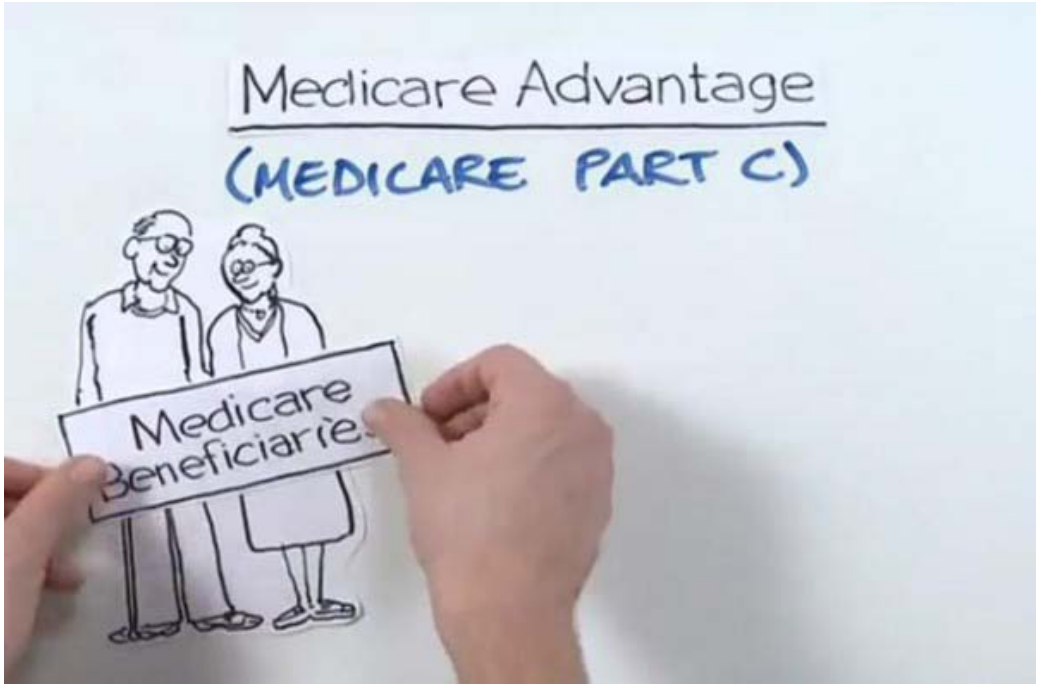
- Most individuals who file an application for Social Security or Railroad Retirement benefits 3 months before they turn age **65** or later are automatically enrolled in Part B unless they refuse Part B coverage.

- Individuals with disabilities who are **under age 65** are automatically enrolled in Part B the earlier of:

  - The month they turn 65 if they have received Social Security or Railroad Retirement benefits for at least 4 months before they turn age 65. They also are given an opportunity to refuse Part B coverage.
  - The month after they have received Social Security or Railroad Retirement disability benefits for 24 months. They also are given an opportunity to refuse Part B coverage

Medicare Entitlement –

- Part C Medicare Advantage Health Plan
  - Individuals who are entitled to benefits under Part A and enrolled under Part B are eligible to enroll in a Medicare Advantage plan.

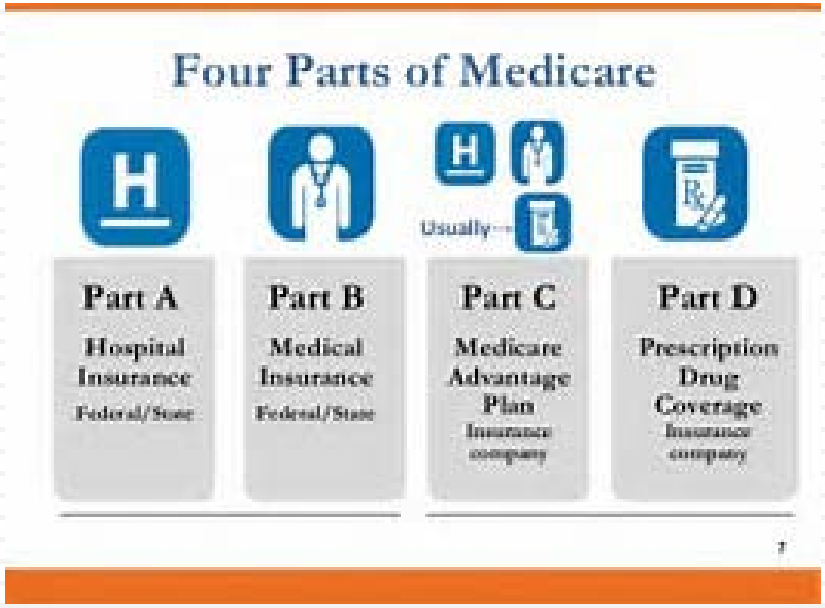


Medicare Entitlement – PART D

- Part D Prescription Drug Benefits
  - Individuals who are entitled to benefits under Part A and/or enrolled under Part B are eligible for Part D prescription drug benefits.

What does it cover?

Benefits and limitations



- Part A helps cover medically necessary inpatient care in hospitals. In 2017, for each benefit period (as defined by Medicare) in a year, beneficiaries pay:
  - $1316 deductible and no coinsurance for a stay of up to 60 days
  - $329 coinsurance per day for days 61-90 of a hospital stay
  - $658 coinsurance per "lifetime reserve day" after day 90 each benefit period (up to 60 days over a beneficiary's lifetime)
  - All costs for each inpatient day beyond 150 days
- Part A does **not** cover custodial or long-term care

PART A - continued

- Blood - In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must do one of these:
  - Pay the hospital costs for the first 3 units of blood you get in a calendar year
  - Have the blood donated
- Hospice care
- Home health care

- Skilled nursing and rehabilitative care only after a three day hospital stay, up to 100 days in a benefit period. ($164.50 coinsurance / day)
- Inpatient psychiatric care (up to 190 lifetime days)

- Part B generally covers:
  - medically necessary physician services;
  - other health care professional services;
  - outpatient hospital;
  - clinical lab and diagnostic tests, therapies, mental health care;
  - medical equipment;
  - medications and supplies provided at the time of physician's service.
- Beneficiaries pay a deductible each year ($183 in 2017), and after the deductible is satisfied, 20% coinsurance on most Part B covered services.

– Preventive Screening & Services

- Beneficiaries will have no cost-sharing for most preventive services.
- Preventive Services include:
  - One-time "Welcome to Medicare" physical exam
  - Annual wellness visit after 12 mos. enrolled in Part B
  - Immunizations – pneumococcal, hepatitis B, annual flu shot
  - Abdominal aortic aneurysm screening – one time, with referral
  - Alcohol misuse screening – every 12 months for certain individuals
  - Bone mass measurement – every 24 months for certain conditions
  - Cardiovascular screening blood tests – every five years for all persons

PART B – Preventive Screening & Services

- Mammogram (Breast Cancer Screening) – annual screening for most women
- Pap test and pelvic examination – every 24 mos. for all women; every 12 mos. for those at high risk
- Colorectal cancer screening – four different tests, vary in frequency
- Depression Screening – every 12 months
- Diabetes screenings – up to two per year for those with risk factors
- Diabetes self-management training – for persons with diabetes
- Glaucoma testing – once per year for those at high risk
- Hepatitis C test – once for all. However, for certain people at high risk Medicare also covers yearly repeat.
- HIV Screening

PART B – Preventive Screening & Services

- Medical nutrition therapy – for those with diabetes/kidney disease or kidney transplant
- Intensive Behavioral Therapy for Cardiovascular Disease – one face-to-face visit annually in a primary care setting
- Obesity Screening and counseling – for certain individuals
- Prostate cancer screening – every 12 mos. for men over age 50
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs – for certain individuals
- Smoking cessation counseling – for any illness related to tobacco use

– Other Services & Items

- Ambulance services
- Ambulatory surgical center fees
- Blood: In most cases, the a Provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the Provider has to buy blood for you, you must do one of these:
  - Pay the Provider costs for the first 3 units of blood you get in a calendar year OR
  - Have the blood donated
- Cardiac rehabilitation – for certain situations
- Chiropractic services – for limited situations
- Clinical research studies – some costs of certain care in approved studies
- Defibrillator (implantable automatic)
- Diabetic supplies

– Other Services & Items

- Foot exams and treatment for certain diabetics
- Eyeglasses after cataract surgery – limits apply
- Hearing and balance exams (no hearing aids)
- Durable medical equipment – restricted to certain suppliers
- Home health services in certain situations
- Kidney dialysis and disease education – certain situations
- Mental health care (outpatient) – limits apply
- Occupational and physical therapy – limits apply
- Prosthetic/Orthotic items
- Pulmonary rehabilitation for COPD

– Other Services & Items

- Second surgical opinions
- Speech-language pathology services
- Tests like X-rays, MRIs, CT scans
- Transplant physician services and drugs
- Emergency room services

NOT Covered by either Part A or Part B

- Acupuncture
- Routine dental care/dentures
- Cosmetic surgery
- Custodial care
- Health care while traveling outside the US – exceptions apply
- Hearing aids
- Orthopedic shoes (with limited exceptions)
- Outpatient prescription drugs (this is covered under Part D)

NOT Covered by either Part 

or 

- Routine eye care and eyeglasses
- Some screening tests and labs
- Vaccines, except as previously listed (those not covered under Part B may be covered under Part D)
- Syringes and insulin unless used with an insulin pump (this is covered under Part D)
- Routine foot care

– Prescription Drug Coverage

- A beneficiary in Original Medicare may receive Part D prescription drug coverage through a stand-alone prescription drug plan (PDP) provided by private insurance companies
- Generally covers most prescribed drugs using
  - Formularies – list of covered drugs
  - Network of Preferred Pharmacies
  - Multiple Pricing Tiers
    - Preferred Generic
    - Generic
    - Preferred Brand Name
    - Brand Name
    - Specialty

– Prescription Drug Coverage

- A beneficiary may also leave Original Medicare and receive drug coverage through a Medicare Advantage health plan (MA-PD)
- Generally, with the exception of those dually eligible for Medicare and Medicaid, Medicare beneficiaries must actively select a Part D plan.
- Annual Enrollment Period - October 15 to December 7
- There is a permanent premium penalty of 1% of the national standard premium for every month that a beneficiary could have had Part D coverage, or equivalent creditable coverage, and chose not to enroll.

– Prescription Drug Coverage

- Beneficiaries who enroll in Part D typically pay a monthly premium, annual deductible and per-prescription cost-sharing.
- Part D plans are sold by independent insurance companies and will vary in price and coverage
- Extra help is available for low-income beneficiaries.
- Beneficiaries with income above $85,000 (individual) or $170,000 (couple) pay an income-related monthly adjustment amount (IRMAA) in addition to the Part D premium.

– Prescription Drug Coverage

- Part D plans must follow the CMS guidelines which include:
  - Deductible Period between $0 and $400 where all costs are paid by beneficiary
  - Initial Coverage between $400 and $3,700 where:
    - Plan pays 75% ($2,475)
    - Beneficiary pays 25% ($825)

PART D – Prescription Drug Coverage

- Coverage Gap (Donut Hole) between $3,700 and ~$8,000 where
  - Plan pays 49% for Generic, 10% for Brand
  - Manufacturer pays 0% for Generic, 50% for Brand
  - Beneficiary pays 51% for Generic, 40% for Brand
  - Maximum Out of Pocket (MOOP) is $4,950
- Items that count towards the coverage gap MOOP:
  - Your yearly deductible, coinsurance, and copayments
  - The discount you get on brand-name drugs in the coverage gap
  - What you pay in the coverage gap
- Items that don't count towards the coverage gap MOOP:
  - The drug plan premium
  - What you pay for drugs that aren't covered

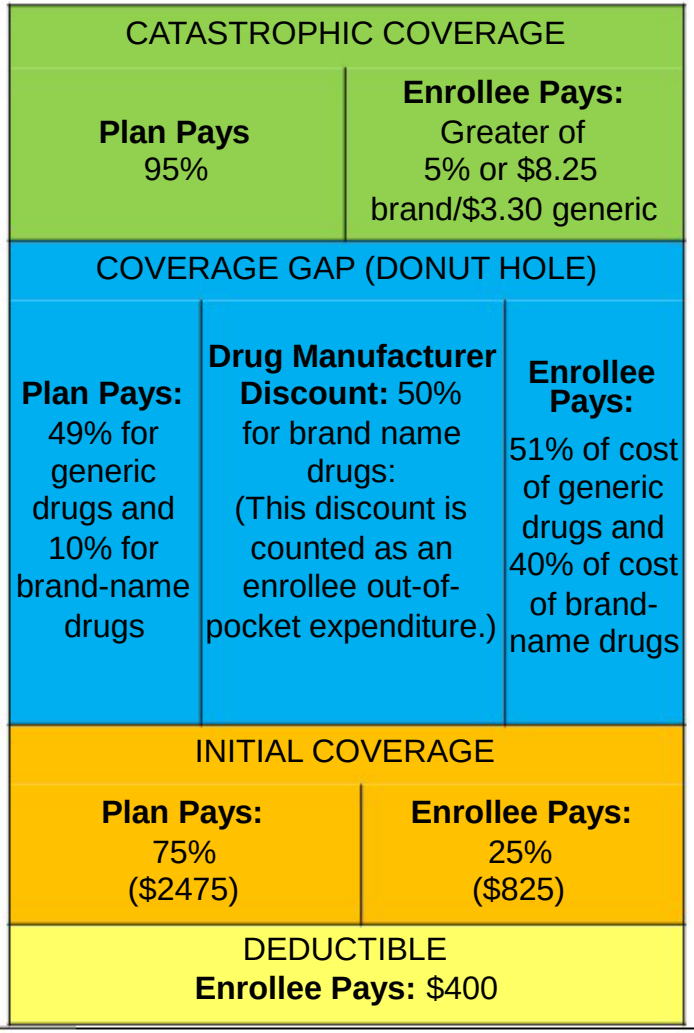
– Prescription Drug Coverage

- Catastrophic Coverage where MOOP > $4,950
  - Plan pays 95%
  - Beneficiary pays greater of 5% or
    - $8.25 Brand
    - $3.30 Generic

Structure of Levels

Total Drug Expenditures

(includes enrollee payment, plan payment & manufacturer discount)



$8071.16 (varies depending on mix of brand-name and generic drugs)

$3,700

$400

$0

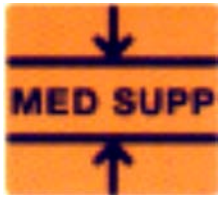
Enrollee Out-of-Pocket Cost

$4,950 - Annual out-of-pocket threshold

$1,225 - Initial Coverage Limit

$400 - Deductible

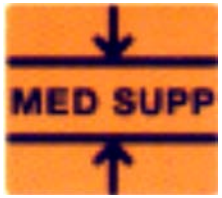
$0



Medigap / Supplement Plans

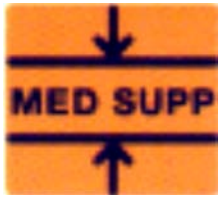
- Medigap Plans help pay all, or a portion, of Part A and Part B coinsurance, copayments, and/or deductibles when Original Medicare determines that a benefit is medically necessary.
- Some Medigap plans also cover benefits not covered by Original Medicare.
- Medigap policies are available in standardized benefit plans, identified by the letters A – N.

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K**	L**	M	N
Part A Coinsurance up to an addition 365 days	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓
*Plan F has a high-deductible plan *** Plan N pays 100% Part B coinsurance with copay up to $20/$50 for emergency room visits not resulting in inpatient							Out-of-Pocket Limit**			
							$4,660	$2,330		



Medigap / Supplement Plans

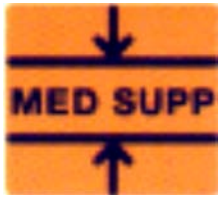
- Most Medigap plans pay for some or all of the following costs:
  - **Part A:**
    - Part A Coinsurance and Hospital Benefits
    - Part A Deductible
    - Coverage for 365 Additional Hospital Days when Medicare coverage ends
    - Hospice Care Coinsurance or Copayment
    - Skilled Nursing Facility Care Coinsurance
    - Blood (First 3 pints)



Medigap / Supplement Plans

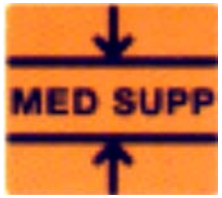
- **Part B:**
  - Part B Coinsurance or Copayment
  - Part B Deductible
  - Part B Excess Charges
  - Blood (First 3 pints) (also under part A)

- **Other :**
  - Foreign Travel Emergency not covered by Medicare
  - Non-Medicare-covered Preventive Services



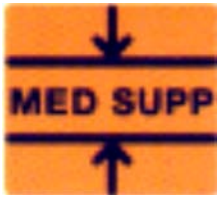
Medigap / Supplement Plans

- Individuals who are enrolled in Medigap plans may only obtain Medicare drug coverage (Part D) through a stand-alone prescription drug plan.
- Medigap is **NOT** a Medicare Advantage health plan or other Medicare health plan.
- Medigap supplements Original Medicare benefits only.
- A Medigap plan cannot be used with a Medicare advantage health plan.



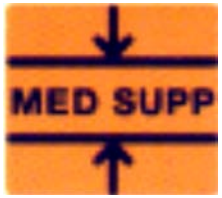
Medigap / Supplement Plans

- What is **NOT** a Medigap / Supplement policy:
  - Medicare Part A or Part B
  - Medicare Advantage Plans (Part C)
  - Medicare Prescription Drug Plans (Part D)
  - Medicaid
  - Employer or union plans
  - TRICARE
  - Veterans' Administration (VA) benefits
  - Long-term care insurance policies



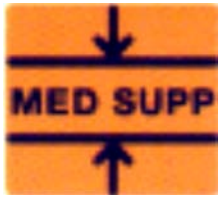
Medigap / Supplement – Plans

Benefit Coverages	A	B	C	D	F	G	K	L	M	N
Part A Coinsurance or Copayment										
Part B Coinsurance or Copayment							50%	75%		
Blood (First 3 pints)							50%	75%		
Part A Hospice Care Coinsurance/Copayment							50%	75%		
Skilled Nursing Facility Care Coinsurance							50%	75%		
Part A Deductible							50%	75%	50%	
Part B Deductible										
Part B Excess Charges										
Foreign Travel Emergency			80%	80%	80%	80%			80%	80%



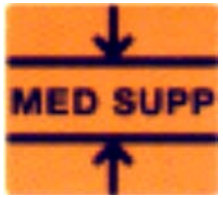
Medigap / Supplement Plans

- New policies effective on or after June 1, 2010, will cover Hospice Part A coinsurance or copayment. (Plan K will cover 50%, and Plan L will cover 75% of these costs.)
- Plans D and G bought on or after June 1, 2010 have different benefits than D or G plans bought before June 1, 2010, but benefits won't change for beneficiaries who had these policies before June 1, 2010.
- All plans pay 100% of the Part B coinsurance except:
  - Plans K and L pay a portion of Part B coinsurance until beneficiaries reach their out of pocket limit ($4,940 for K and $2, 470 for L). Then they pay 100%.
- Plan N requires beneficiaries to make copayments for office and emergency room visits.
- Plans E, H, I, and J are no longer sold, but beneficiaries with those plans may keep them.



Medigap / Supplement Plans

- Medigap Plan differences:
  - Plan F also offers a high-deductible plan
  - The Foreign Travel benefit pays 80% after a $250 deductible up to $50,000 lifetime maximum
  - Plans K and L pay 100% after out-of-pocket limit is reached ($5,120 for K and $2,560 for L)
  - Plan N requires beneficiaries to make copayments of up to $20 for office visits and $50 for emergency room visits.



Medigap / Supplement Plans

- Turning age 65 and signing up for Part B triggers a six-month Medigap open enrollment period when Medigap plans must be issued, regardless of any pre-existing conditions, called a guaranteed issue right.
- In limited circumstances, leaving a Medicare Advantage plan will trigger a guarantee issue opportunity.
- Otherwise medical underwriting and possibly higher premiums may be triggered.

What does it cost?

2017 Premiums, Deductibles, Coinsurance, Copayments and Out of Pocket (OOP) Costs

Costs

- Premium –
  - Enrollees who paid Medicare taxes for at least 10 years (or their spouse) - $0.00
  - Enrollees who have to buy Part A – up to $413.00 depending on Medicare taxes paid
  - Possible 10% late enrollment fee every year until twice the number of years enrolled late

Costs

- Deductibles for hospitalization
  - $1,316 for each benefit period
    - The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services.
    - A benefit period begins the day you're admitted as an inpatient in a hospital or SNF.
    - The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.
    - If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period.
    - There's no limit to the number of benefit periods.

Costs

- Coinsurance for hospitalization
  - Days 1–60: $0 coinsurance for each benefit period.
  - Days 61–90: $329 coinsurance per day of each benefit period.
  - Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
  - After 60 lifetime reserve days pay all costs

Costs Example

- Based on 2017 rates
- Sample Hospital Stay starting Jan 1
- Day Rate = $750
- Left hospital on Apr 18
- End of first benefit period on June 17

Period - days	Hospital Bill	Medicare Pays	You Pay	Your Total Cost
1 – 60	$45,000	$43,684	$1,316	$1,316
61 – 90	$22,500	$12,630	$9,870	$11,186
91 – 108	$13,500	$1,660	$11,840	$23,026
Totals	$81,000	$57,974	$23,026	

Costs

- **Home health care**
  - $0 for home health care services.
  - 20% of the Medicare approved amount for durable medical equipment.
- **Hospice care**
  - $0 for hospice care.
  - You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D.
  - You may need to pay 5% of the Medicare approved amount for inpatient respite care.
  - Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).

Costs

- **Mental health inpatient stay – you pay**
  - $1,316 deductible for each benefit period.
  - Days 1–60: $0 coinsurance per day of each benefit period.
  - Days 61–90: $329 coinsurance per day of each benefit period.
  - Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
  - After lifetime benefit days: all costs.
  - 20% of the Medicare approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.

Costs

- **Skilled nursing facility stay – you pay**
  - Days 1–20: $0 for each benefit period .
  - Days 21–100: $164.50 coinsurance per day of each benefit period.
  - Days 101 and beyond: all costs.
- **Not covered**
  - You pay for private-duty nursing, a television, or a phone in your room.
  - You pay for a private room unless it's medically necessary.

Costs

- Premium – (2017 rates)
  - Hold-Harmless prior enrollees usually $109.00
  - New enrollees and those who pay directly or are subject to income related adjustments

Filed Individual Tax Return Income Bracket in $1,000s	Filed Joint Tax Return Income Bracket in $1,000s	Income related monthly adjustment	Total monthly premium
<= $85	< $170	$0.00	$134.00
> $85 <= $107	> $170 <= $214	$53.50	$187.50
> $107 <= $160	> $214 <= $320	$133.90	$267.90
> $160 <= $214	> $320 <= $428	$214.30	$348.30
> $214	> $428	$294.60	$428.60

Costs

- Premium –
  - New enrollees who are Married filing separate tax returns and who pay directly or are subject to income related adjustments

Married and filed Separate tax Return Income Bracket in $1,000s	Income related monthly adjustment	Total monthly premium
<= $85	$0.00	$134.00
> $85 <= $129	$214.30	$348.30
> $129	$294.60	$428.60

Costs

- Annual Deductible – $183.00
- Coinsurance – 20% of standard Medicare approved charges after the deductible
- Excess Charges – any amount over the standard Medicare approved charges if Provider does not accept full payment from Medicare

Costs

- Premium –
  - Depending on various conditions the premiums can be as little as Zero and are set by the issuing insurance companies
  - Determining factors include:
    - Issuing insurance company
    - State where plan is offered
    - Structure of plan (HMO, PPO, etc.)
    - If part D is included
    - Level of benefits
    - Additional coverage or features

Costs Example

- Sample Premiums for Advantage Plans in Kent County, DE

Plan Type	Monthly Premium	Part D Deductible	Donut Hole Coverage **	MOOP
HMO	NONE	NONE	YES	$6,700
HMO	NONE	$280	NO	$6,700
HMO	$27	$280	YES	$6,700
PPO	$72	$400	YES	$6,700
HMO	$78	NONE	YES	$6,700
PPO	$113	NONE	YES	$6,700

Costs Example

- Sample Premiums for Advantage Plans in Sussex County, DE

Plan Type	Monthly Premium	Part D Deductible	Donut Hole Coverage **	MOOP
HMO	NONE	NONE	YES	$6,700
HMO	$78	NONE	YES	$6,700
PPO	$113	NONE	YES	$6,700

**

No: you must pay the $3,725;

Yes: This plan offers some level of gap coverage

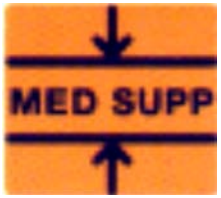
Costs

- Premium –
  - Depending on various conditions the premiums can be as little as Zero and are set by the issuing insurance companies
  - Determining factors include:
    - Issuing insurance company
    - State where plan is offered
    - Level of benefits
    - Additional coverage or features

Costs Examples

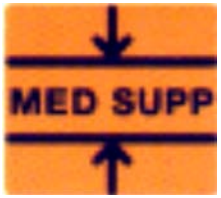
- Sample Premiums for Drug Plans in DE

Monthly Premium	Part D Deductible	GAP Cover **	Tier Copays for 30 day supply	Total Drugs
$14.60	$270	NO	1/15/10%/25%/37%	2899
$33.90	NONE	NO	3/19/47/50%/33%	3073
$66.90	NONE	NO	5/10/35/40%/33%	NA
$17.00	$400	NO	1/4/20%/35%/25%	3375
$33.40	$400	NO	1/2/23/30%/25%	NA
$33.20	$360	NO	1/2/30/33%/25%	NA
$29.40	$400	NO	0/1/20%/35%/25%	3286



Policy Costs

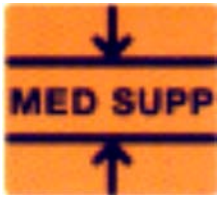
- Premium –
  - Depending on various conditions the premiums can be different and are set by the issuing insurance companies
  - Each of the current 11 plans will have different premiums
  - Determining factors include:
    - Rating Method to determine premiums
    - Issuing insurance company
    - State where plan is offered
    - Level of benefits – plans A thru N
    - Additional coverage or features



Policy Costs

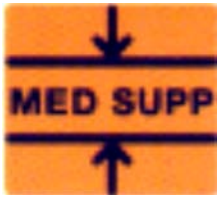
- Sample Premiums for Medigap plans in DE

Plan Type	Premium Range (mo)	Annual Cost Est.		Plan Type	Premium Range (mo)	Annual Cost Est.
A	$77 - 267	$7,530		G	$117 – 210	$7,570
B	$100 - 304	$7,600		K	$45 – 98	$7,380
C	$130 - 345	$7,710		L	$80 – 138	$7,470
D	$99 – 208	$7,350		M	$144	$8,070
F	$131 – 284	$7,720		N	$95 – 162	$7,560
F-HD	$29 – 101	$7,360				



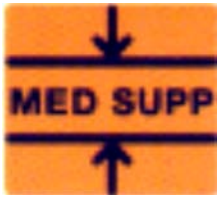
Medigap / Supplement – Plans

Benefit Coverages	A	B	C	D	F	G	K	L	M	N
Part A Coinsurance or Copayment										
Part B Coinsurance or Copayment							50%	75%		
Blood (First 3 pints)							50%	75%		
Part A Hospice Care Coinsurance/Copayment							50%	75%		
Skilled Nursing Facility Care Coinsurance							50%	75%		
Part A Deductible							50%	75%	50%	
Part B Deductible										
Part B Excess Charges										
Foreign Travel Emergency			80%	80%	80%	80%			80%	80%



Policy Costs

- Types of Rating methods
  - Community Rated (also called “no age-rated”)
    - No age based increases but can increase due to inflation
  - Issue-age-rated (also called “entry age-rated”)
    - Based on age when purchased – cheaper when younger - won’t go up based on age
  - Attained-age-rated
    - Based on current year age and will go up as you get older



Policy Costs

- Possible Discounts
  - For Women
  - For non-smokers
  - For being married when both buy ploicies
  - For paying yearly
  - For using electronic funds transfers
- May be medically underwritten when not qualified for guaranteed issue

When can you get it?

Various allowable Enrollment periods for each type of coverage

Enrollment

- Initial Enrollment Period – 7 months
  - Begins 3 months before the month you turn 65
  - Includes the month you turn 65
  - Ends 3 months after the month you turn 65
- Open Enrollment Period
  - January 1 thru March 31 each year
- Special Enrollment Periods - SEP
  - 8 months
  - After you are no longer covered by an employer group health plan

Enrollment

The 3 Medicare enrollment periods

Enrollment period	When used	Period
Initial Enrollment Period (IEP)	When eligible individual turns 65.	Seven months long beginning three full months before the month in which an individual turns age 65. It ends three full months after the month of the individual's 65th birthday.
Special Enrollment Period (SEP)	Any time after the IEP when an eligible individual loses coverage in an employer-provided group health plan.	Flexible: It can be used any time an eligible individual decides to terminate coverage in an employer-provided group health plan and his or her IEP is not available. Medicare Part B coverage begins the month following enrollment. If coverage is lost due to termination of employment or plan termination, the enrollment period is eight months.
General Enrollment Period (GEP)	When the IEP or the SEP is not available.	Jan. 1 through March 31 of each year. Medicare participation does not begin until July 1.

Source: *Medicare General Information, Eligibility, and Entitlement Manual*, Centers for Medicare & Medicaid Services.

Enrollment

Your Medicare Start Date Depends on Your Timing

The Medicare Initial Enrollment Period Is 7 Months Long

If you enroll:

Month 1	Month 2	Month 3	Month of First Eligibility	Month 5	Month 6	Month 7
3 Months Prior	2 Months Prior	1 Month Prior	Month of 65th birthday or 25th month of disability	1 Month After	2 Months After	3 Months After

Your coverage starts the first day of:

Month of First Eligibility	1 Month After You Enroll	2 Months After You Enroll	3 Months After You Enroll
Or month prior to the month of 65th birthday, if the birthday falls on the first of the month			

MA & PART D Enrollment

- Initial Enrollment Period – 7 months
  - Begins 3 months before the month you turn 65
  - Includes the month you turn 65
  - Ends 3 months after the month you turn 65
- Open Enrollment Period
  - October 15 thru December 7 each year

MA & PART D Enrollment

- What you can do during Open Enrollment
  - Change from Original Medicare to a Medicare Advantage Plan.
  - Change from a Medicare Advantage Plan back to Original Medicare.
  - Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
  - Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
  - Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
  - Join a Medicare Prescription Drug Plan.
  - Switch from one Medicare drug plan to another Medicare drug plan.
  - Drop your Medicare prescription drug coverage completely.

Enrollment

- **Medicare Advantage Disenrollment Period**
  - January 1–February 14
  - **What can I do?**
    - If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare.
    - If you switch to Original Medicare during this period, you'll have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form.
  - **What can't I do?**
    - Switch from Original Medicare to a Medicare Advantage Plan.
    - Switch from one Medicare Advantage Plan to another.
    - Switch from one Medicare Prescription Drug Plan to another.

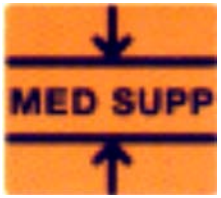
Enrollment

Open Enrollment Period

- 6-month Medigap open enrollment period.
- This period automatically starts the month you're 65 and enrolled in Medicare Part B (Medical Insurance).
- Your Medigap open enrollment period begins when you enroll in Part B and can't be changed or repeated
- If you have group health insurance through an employer or union, your Medigap open enrollment period will start when you sign up for Part B.
- During that time you can buy any Medigap policy sold in your state, even if you have health problems.
- After this enrollment period, you may not be able to buy a Medigap policy. If you're able to buy one, it may cost more.

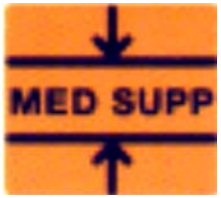
Enrollment

- **Outside open enrollment**
  - There's no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements. This means the company can do any of these things because of your health problems:
    - Refuse to sell you any Medigap policy it sells
    - Make you wait for coverage to start
    - Charge you more for a Medigap policy



Enrollment

- **Outside open enrollment**
  - In some cases, an insurance company must sell you a Medigap policy, even if you have health problems. You're guaranteed the right to buy a Medigap policy:
    - When you're in your Medigap open enrollment period
    - If you have a guaranteed issue right
  - You may also buy a Medigap policy at other times, but the insurance company can deny you a Medigap policy based on your health.



Enrollment

- **Guaranteed Issue Rights**
  - Guaranteed issue rights (also called "Medigap protections") are rights you have in certain situations when insurance companies must offer you certain Medigap policies. In these situations, an insurance company:
    - Must sell you a Medigap policy
    - Must cover all your pre-existing health conditions
    - Can't charge you more for a Medigap policy because of past or present health problems

Enrollment

Guaranteed Issue Rights

- You have a guaranteed issue right if
  - You're in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.
  - **You have the right to buy** Medigap Plan A, B, C, F, K, or L that's sold by any insurance company in your state. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage Plan.
  - **You can/must apply for a Medigap policy:**
    - As early as 60 days before the date your coverage will end
    - No later than 63 calendar days after your coverage ends
  - Medigap coverage can't start until your Medicare Advantage Plan coverage ends.

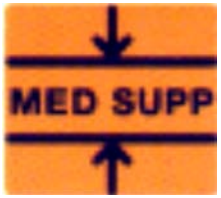
Enrollment

- **Guaranteed Issue Rights – cont'd**
  - You have a guaranteed issue right if
    - You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.
    - **You have the right to buy** Medigap Plan A, B, C, F, K, or L that's sold by any insurance company in your state.
    - **You can/must apply for a Medigap policy** no later than 63 calendar days after the **latest** of these 3 dates:
      - Date the coverage ends
      - Date on the notice you get telling you that coverage is ending
      - Date on a claim denial, if this is the only way you know that your coverage ended

Enrollment

Guaranteed Issue Rights – cont'd

- You have a guaranteed issue right if
  - You dropped a Medigap policy to join a Medicare Advantage Plan for the first time, you've been in the plan less than a year, and you want to switch back. (Trial Right)
  - **You can/must apply for a Medigap policy:**
    - As early as 60 calendar days before the date your coverage will end
    - No later than 63 calendar days after your coverage ends



Enrollment

Guaranteed Issue Rights – cont'd

- You have a guaranteed issue right if
  - Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.
  - You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.

References

The information outlined in this presentation is for educational purposes only. All official information about Medicare can be found at:

Medicare.gov
The Official U.S. Government Site for Medicare

Medicare.gov
The Official U.S. Government Site for Medicare

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.
7500 Security Boulevard,
Baltimore, MD 21244

References

Other related official information about Medicare can be found at:

CMS.gov

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.
7500 Security Boulevard, Baltimore, MD 21244

www.SSA.gov

for information on Social Security

Social Security Administration

Thank You

Thank You for the opportunity to present this information to you today.

If you would like a digital file (PDF) of this presentation please email a request to me at:
danelson2@comcast.net

Also, if you would like further information on obtaining Medicare insurance, or have any questions, please email me at the address above.

Questions

If there are questions now I will get you an answer either today or ASAP, just leave me an email address or a phone number.

Also, if you would like further information on obtaining Medicare insurance, or have any questions, please email me at danelson2@comcast.net

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Part C & D Enrollment – cont'd

- I have Medicare Part A coverage, and I enrolled in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).
  - **What can I do?**
    - Sign up for a Medicare Prescription Drug Plan.
  - **When?**
    - April 1–June 30

Part C & D Enrollment – cont'd

- I do not have Medicare Part A coverage, and I enrolled in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).
  - **What can I do?**
    - Sign up for a Medicare Prescription Drug Plan.
  - **When?**
    - April 1–June 30