

Medicare 101 | 2012

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Medicare Overview

Medicare is the nation’s largest health insurance program offered to seniors (65 years or older) and other eligible beneficiaries. Medicare was established to provide health insurance benefits to Americans receiving social security (typically, retired workers). Medicare is a Federal insurance program, managed by the Center for Medicare & Medicaid Services (CMS).

Medicare Benefits

Medicare Part A – Hospital Insurance

Medicare Part A insurance provides hospital benefits, including care at skilled nursing facilities, home healthcare and hospice care. Typically, there is no monthly premium for Medicare Part A insurance if you or your spouse paid Medicare taxes for at least 10 years while working.

Hospital Visits

Hospital Stay	Your cost	Notes
Days: 1 – 60	\$1,132.00 deductible	The deductible is not an annual deductible but rather a deductible for each hospital stay as long as the hospital stay doesn’t happen 60 days from your last hospital stay.
Days: 61 – 90	\$283.00 per day	
Days: 91 – 150	\$566.00 per day	
Days: 150+	No coverage	After 150 days in the hospital, the Medicare beneficiary is required to pay the full hospital costs.

Skilled Nursing Facility (SNF)

SNF Stay	Your cost	Notes
Days: 1 – 20	\$0.00	The first 20 days in a Skilled Nursing Facility are paid for by Medicare.
Days: 21 – 100	\$141.50 per day	
Days: 100+	No coverage	After 100 days in a skilled nursing facility, the Medicare beneficiary is required to pay the full healthcare costs.

Home Health – there are no copays, coinsurance, or deductibles for home healthcare, but you are required to meet a number of guidelines in order to be eligible to receive home healthcare.

Hospice – there are no copays, coinsurance, or deductibles for hospice care except for outpatient drugs (\$5 copay) and inpatient respite care (5% coinsurance).

Medicare Part B – Medical Insurance

Medicare Part B provides insurance to help cover doctors’ services, outpatient care and other medically necessary services, including laboratory tests, medical equipment, and other services not covered by Medicare Part A. For most Part B services, Medicare beneficiaries are required to pay 20% coinsurance after paying the Medicare Part B deductible of \$162.00 per year. The standard monthly premium for Medicare Part B in 2011 is \$115.40 but this may vary based on your modified adjusted gross income (NOTE: if you received Social Security benefits in 2010 and you made less than \$85,000 as an individual or less than \$170,000 as a couple, your 2011 Part B premium is \$96.40.). For a complete breakdown of Medicare Part B premiums, see Medicare Part B premium under the Medicare Cost section.

2011 Medicare Part B Premiums

Part B Benefits	Your cost
Doctors’ services	20% coinsurance
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays/ medical equipment	20% coinsurance
Physical, speech and occupational therapy	20% coinsurance
Clinical diagnostic laboratory services	No coinsurance
Home healthcare	No coinsurance
Outpatient mental services	50% coinsurance

Medicare Doctors – be sure your doctor accepts Medicare (also known as the Medicare Assignment). As long as your provider accepts Medicare, you will pay 20% coinsurance for the specified Part B services. If the provider agrees to see Medicare patients but doesn’t accept the Medicare Assignment, they are able to charge up to 15% more than the Medicare reimbursement rate. If you choose to see this provider, you will be responsible for paying the 15% in addition to the 20% coinsurance amount.

Also, providers may opt out of Medicare at any time. If your provider no longer provides services to Medicare patients, you will be responsible to pay the full cost of the services. If this is the case, doctors should notify you as a courtesy that they don’t accept Medicare and that you are responsible to pay the full medical bill before they provide service to you.

Medicare Part C – Medicare Advantage (Private Hospital & Medical Insurance)

Medicare Part C, or Medicare Advantage, is the combination of Medicare Part A and Medicare Part B and may also include prescription drug coverage (Medicare Part D). Medicare Advantage is a Federal program but it is sold through private health insurance companies, such as UnitedHealth Group, AARP, Humana, and others in the form of a Medicare HMO, PPO or other plan types. Sometimes, Medicare Advantage plans contain additional benefits that are not included in the Original Medicare Part A and Part B plans, such as vision and dental coverage.

With Medicare Advantage plans, Medicare pays a fixed amount for your care every month to the insurance companies (for example, AARP or Humana). These private insurance companies must provide you with minimum health benefits set by Medicare.

Also, it is important to note that if you choose a Medicare Advantage plan, you may not purchase a Medicare Supplemental insurance plan (Medigap). You may only purchase Medigap with an Original Medicare Part A and Part B plan.

Types of Medicare Advantage Plans

- **Health Maintenance Organization (HMO)** – Medicare HMO plans cover Medicare Part A and Part B. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan’s network except in an emergency. Your costs may be lower than in Original Medicare.
- **Preferred Provider Organization (PPO)** – Medicare PPO plans cover Medicare Part A and Part B. With a Medicare PPO plan, you typically pay less if you use doctors, hospitals, and providers that belong to the network. You can also use doctors, hospitals and providers outside of the network for an additional cost.
- **Private Fee-for-Service (PFFS)** – Medicare PFFS plans cover Medicare Part A and Part B. Medicare PFFS plans permit you to go to any Medicare-approved doctor or hospital that accepts the plan’s payment. The PFFS insurance plan, rather than Medicare, decides how much it will pay doctors for treating you and what your coinsurance or copay will be for the services you receive. Unlike with an HMO or PPO network, the doctor or hospital may start or stop accepting the PFFS plan’s payment at any time.
- **Medical Savings Account (MSA)** – Medicare MSA plans cover Medicare Part A and Part B. The MSA plans have two parts: 1) the first part is a high deductible Medicare MSA plan. This plan won’t begin to pay covered costs until you have met the annual deductible, which varies by plan. 2) the second part is a Medical Savings Account into which Medicare deposits money that you may use to pay healthcare costs.
- **Special Needs Plan (SNP)** – Medicare SNP plans are a special type of Medicare Advantage plan that provides all Medicare Part A and Part B healthcare and services to people who can benefit the most from things like special care for chronic illnesses, care management of multiple diseases, and focused care management. These plans may limit membership to people:

- In certain institutions (like a nursing home),
- Eligible for both Medicare and Medicaid, or
- With certain chronic or disabling conditions.

Note: In most cases, Medicare Advantage plans, especially HMOs and PPOs, include prescription drug coverage (Part D). These plans are commonly referred to as Medicare Advantage Prescription Drug Plans or MAPD. If you purchase a Medicare Advantage plan without prescription drug coverage you will need to sign up for a Medicare Part D plan separately if you want prescription drug coverage.

Medicare Part D – Prescription Drug Insurance

Prior to 2006, Medicare beneficiaries paid cash for their prescription drugs, or purchased drugs with a Medicare discount drug card. Starting on January 1st, 2006, Medicare offered a prescription drug insurance program called Medicare Part D. Similar to Medicare Advantage, Medicare Part D is managed by Medicare but offered through private insurance companies.

When you sign up for a Medicare Part D plan, you will pay a separate premium from your Part A and Part B premium, unless you sign up for a Medicare Advantage plan that includes Medicare Part D. In this case, the Medicare Part D premium is included in the Medicare Advantage premium.

If you decide to enroll in a Medicare Part D plan separate from your Part A and Part B insurance, you should be sure to use a tool that will help you compare prescription drug costs. Private insurance companies vary greatly with how much they charge for plan premiums and the costs of each drug. In addition, the private health insurance companies that offer Medicare Part D do not include all drugs on their formularies so it is important that you select a plan that covers your drugs.

Finally, the premiums and drug costs for Medicare Part D offered by private insurance companies can change each year. For example, in one year, you may select a plan with the lowest cost, but the next year, that very same plan may have increased its premium and drug costs and may no longer be the best value for you. This is why it is important to compare plans each year to make sure you are receiving the best prescription drug coverage at an affordable price.

Medigap – Medicare Supplemental Insurance, or “MedSup”

Medigap is a supplemental insurance policy to help provide additional coverage for Medicare Part A and Medicare Part B (Original Medicare). A Medigap insurance policy, sold by private insurance companies, can help pay some of the healthcare costs (“gaps”) that Original Medicare (Medicare Part A and Medicare Part B) doesn’t cover, such as, coinsurance and deductibles.

Medicare has created 10 standardized Medigap plans, labeled Medigap A – N (except in Massachusetts, Minnesota and Wisconsin—to view information about plans in these states go to:

<http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>; pages 41-44). Each standardized Medigap policy must offer the same basic coverage, no matter which insurance company sells it. Cost is usually the only difference between Medigap policies with the same letter name sold by different insurance companies.

If you purchase your Medicare Part A and Part B through a Medicare Advantage plan rather than Original Medicare, you are not eligible to purchase a Medigap insurance policy. Medigap policies only work with Original Medicare

Medigap Plans A through N - Summarized

Medigap Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A Coinsurance and all costs after hospital benefits are exhausted.	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Copay for other than preventive services.	X	X	X	X	X	X	50%	75%	X	X****
Blood (First 3 Pints)	X	X	X	X	X	X	50%	75%	X	X
Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B Deductible			X		X					
Medicare Part B Excess Charges					X	X				
Foreign Travel Emergency (up to Plan Limits)**			X	X	X	X			X	X
Medicare Preventive Care Part B Coinsurance	X	X	X	X	X	X	X	X	X	X
Out-of-Pocket Limit***							\$4,640	\$2,620		

* Medigap Plan F also offers a high-deductible option. You must pay for Medicare-covered costs up to the high-deductible amount (\$2,000 in 2010) before your Medigap policy pays anything.

** You must also pay a separate deductible for foreign travel emergency (\$250 per year).

*** After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$162 in 2011), the Medigap plan pays 100% of covered services for the rest of the calendar year. Out-of-pocket limit is the maximum amount you would pay for coinsurance and copayments.

**** Plan N pays 100% of the Part B coinsurance except up to \$20 copayment for office visits and up to \$50 for emergency department visits. (Note: A box marked with an "X" indicates that the Medigap plan covers 100% of the described benefit. If the box has a percentage then the plan only covers the listed percentage of that benefit. And, if the box is empty, the Medigap plan does not provide any coverage for the benefit)

Medigap plans do not cover long-term care (for example, care provided by a nursing home), vision or dental care, hearing aids, eyeglasses, and private-duty nursing.

Choosing a Medicare Plan

As a beneficiary who is eligible for Medicare, you may find it difficult selecting the appropriate Medicare coverage for you. Medicare can be challenging as you first have to choose whether to purchase your health insurance directly from the government (Original Medicare) or whether to purchase it from private health insurance companies (Medicare Advantage).

The table below demonstrates the options for each path:

Step 1: Decide if you want Original Medicare or Medicare Advantage	
Original Medicare	Medicare Advantage Plan (Medicare HMO, PPO or PFFS)
<p>Part A (Hospital Insurance) and Part B (Medical Insurance) Medicare provides this coverage.</p> <ul style="list-style-type: none"> You have your choice of doctors, hospitals, and other providers. Generally, you pay deductibles and coinsurance. You usually pay a monthly premium for Part B. 	<p>Medicare Advantage—includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)</p> <ul style="list-style-type: none"> Private insurance companies approved by Medicare provide this coverage. In most plans, you need to use plan doctors, hospitals, and other providers or you pay more. You usually pay a monthly premium (in addition to your Part B premium) and a copay for covered services. Costs, extra coverage and rules vary by plan.
Step 2: Decide if you want Prescription Drug Coverage (Medicare Part D)	
<ul style="list-style-type: none"> If you want this coverage, you must choose and join a Medicare Prescription Drug plan. These plans are run by private companies approved by Medicare. 	<ul style="list-style-type: none"> If you want this coverage, in most cases you must get it through your Medicare Advantage plan. Most Medicare Advantage plans include prescription drug coverage (Part D), usually for an extra cost. If your Medicare Advantage plan of choice does not include prescription drug coverage, you may join a Prescription Drug plan separately.
Step 3: Decide if you want supplemental coverage (Med Sup)	
<ul style="list-style-type: none"> If you want this coverage, you must purchase this coverage from private insurance companies. These plans are run by private companies approved by the states in which they are sold. 	<ul style="list-style-type: none"> Medicare Supplemental Insurance plans are not available to beneficiaries with Medicare Advantage plans.

Enrollment

Medicare has established specific timelines for enrolling in a Medicare plan. It is important that you enroll during your initial enrollment period to avoid additional costs. As you may be aware, Medicare has the right to apply a financial penalty to your Medicare premium if you enroll late. In addition, if you plan to enroll in a Medigap plan and don't do so during your initial enrollment period, Medigap plans have the ability to factor in your health conditions and charge you a higher premium based on your health profile. This is why it is important that you consider your Medicare options early to avoid penalties.

To help you understand when you are eligible to enroll in a Medicare plan or change your plan, we have provided the following information below:

Enrolling in Medicare for the first time

If you are enrolling in Medicare insurance for the first time, you are eligible to enroll during the following periods:

- **Turning 65:** If you are turning 65 and enrolling in Medicare for the first time, you are eligible to enroll in a plan beginning 3 months before you turn 65 and up until 3 months after your 65th birthday. Note: If enrolling in a Medigap plan, your enrollment period will last for 6 months beginning in the month that you turn 65. Some states have additional open enrollment periods.
- **Medicare eligible because of a disability:** If you receive Medicare due to a disability, you may enroll in a Medicare plan beginning 3 months before and up to 3 months after your 25th month of disability.

Switching Medicare Plans

After you become eligible for Medicare insurance, you are only allowed to change or switch your Medicare insurance during certain periods throughout the year. The Medicare enrollment periods for changing plans are outlined in this section. Note: If you are eligible to change Medicare plans, you should simply join another plan—this will automatically disenroll you from your old plan.

- **Annual Election Period "AEP"**(October 15th – December 7th): during the Annual Election Period, you may change the following Medicare insurance:

Medicare Part B (Medical insurance) – switch from Original Medicare to a Medicare Advantage plan.

Medicare Advantage (Hospital, Medical and sometimes Prescription Drug insurance) – switch to another Medicare Advantage plan or switch back to Original Medicare.

Medicare Part D (Prescription Drug insurance) – switch to another Medicare Part D plan or switch to a Medicare Advantage plan that includes prescription drug insurance.

• **The Medicare Advantage Disenrollment Period “MADP”** (January 1 through February 14): During the MADP you can make changes only if you have a Medicare private health plan. Medicare private health plans are also known as Medicare Advantage (MA) plans. You can add or drop drug coverage when you are switching to Original Medicare. You cannot make any changes if you have Original Medicare. If you disenroll from your Medicare private health plan (Medicare Advantage), the laws in your state may allow you to enroll in a Medigap plan. You should check with your SHIP (State Health Insurance Assistance Program) to find out. You can find the number for your local SHIP by calling 800-MEDICARE.

Accepted Medicare plan changes during the Medicare Advantage Disenrollment Period:

No	If current coverage is:	Can use MADP to get:
1.	A Medicare private health plan with drug coverage (Medicare Advantage plan with prescription drug coverage - MAPD)	Original Medicare and a prescription drug plan or Original Medicare without a prescription drug plan
2.	A Medicare Private Fee-For-Service (PFFS) plan that does not have prescription drug coverage and a stand-alone prescription drug plan (MA and PDP)	Original Medicare, but you must keep your current prescription drug plan
3.	A Medicare Private Fee-For-Service (PFFS) plan that does not have prescription drug coverage.	Original Medicare and a prescription drug plan
4.	Original Medicare or Original Medicare and a prescription drug plan	You cannot switch your plan during this time

Special Enrollment Period "SEP"

Medicare has established a special enrollment period to allow you to enroll or change plans if you qualify with special circumstances. Below are a list of conditions and rules for enrolling outside of the Annual Election Period and the Open Enrollment Period.

No.	Special Enrollment Reason	Enrollment Period
1.	I am new to Medicare.	If you are newly eligible for Medicare, you can join a Medicare drug plan during the 7-month period which starts 3 months before the month you are eligible for Medicare and ends 3 months after your Medicare becomes effective. This is true if you are eligible for Medicare because of age or disability.
2.	I recently moved outside of the service area for my current plan.	You are eligible to change plans beginning the month before you move and up to two months after you move. You must notify your current plan that you are moving. Be sure to check that they do not offer service in the area where you are moving. Please keep in mind that if you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan.
3.	I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.	You can join, switch, or disenroll at any time. The effective date will be the first day of the month after the plan receives the request. If you lose your Medicaid or Medicare Savings Program status, you get a special enrollment period to join a different drug plan. This special enrollment period begins the month that you lose Medicaid or Medicare Savings Program eligibility and ends 2 months later. Please keep in mind that if you want to switch plans, you should simply join another one. This will automatically disenroll you from your old plan.
4.	My plan is ending its contract with Medicare.	If your plan ends its contract with Medicare, it is required to notify you 60 days before the termination date. You will be able to change plans beginning 60 days before the termination date and up to one month after the month in which the termination occurs.
5.	I live in a Long Term Care Facility (for example, a nursing home or rehabilitation hospital).	If you are moving into or already live in a long term care facility, you may enroll, switch or disenroll at any time while you're in the facility. Once you leave, this opportunity lasts up to 2 months after you leave the facility.
6.	I recently "left" a Program of All-inclusive Care for the Elderly (PACE) program.	If you disenroll from a Program of All-inclusive Care for the Elderly (PACE), you have 2 months to join a Medicare drug plan.
7.	I am moving into or out of a Long Term Care Facility (for example, a nursing home or rehabilitation hospital).	If you enter or live in a long term care facility, you get a special enrollment period for the time you're in the facility. Once you leave, you will get another special enrollment period to switch plans that lasts up to 2 months after you leave the facility.

<p>8. I recently involuntarily lost my creditable drug coverage.</p>	<p>The special enrollment period begins the month that you're told of the loss of creditable coverage and either ends 2 months after the loss or 2 months after you're told, whichever is later. If the coverage is lost because you didn't pay your premiums, you won't get a special enrollment period.</p>
<p>9. I am losing coverage I had from an employer.</p>	<p>The special enrollment period begins the month that you're told of the loss of creditable coverage and either ends 2 months after the loss or 2 months after you're told, whichever is later. If the coverage is lost because you didn't pay your premiums, you won't get a special enrollment period.</p>
<p>10. I am currently receiving extra help paying for Medicare prescription drug coverage, but do not have Medicaid.</p>	<p>You get a special enrollment period to enroll, switch or disenroll while you are receiving the extra help.</p>
<p>11. I belong to a pharmacy assistance program provided by my state, or I am losing or recently lost participation in such a program.</p>	<p>You get one chance per calendar year to join, switch or disenroll drug plans if you are in a qualified State Pharmacy Assistance Program (SPAP).</p>
<p>12. I recently returned to the United States after living permanently outside of the U.S.</p>	<p>You can join a Medicare drug plan in your new area as early as the first day of the month before you move (coverage starts on the first day of the month after the month you request enrollment). This way, your new coverage will begin the first day of the month in which you move. Or, you can join up to 2 months after you move. The effective date will be the first day of the month after the new plan receives the request. When you apply for the new plan, be sure to give them your new address. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment or disenrollment. Your plan may contact you for more information.</p>
<p>13. In the last 12 months, I left a Medigap policy to join a Medicare Advantage plan for the first time (Medicare Advantage plan with prescription drug coverage).</p>	<p>You may be eligible for a special enrollment period to leave your Medicare Advantage plan with prescription drug coverage to return to either Original Medicare or the Medigap plan that you left (if still available) and select a Medicare Prescription Drug plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information.</p>
<p>14. In the last 12 months, I joined a Medicare Advantage plan with prescription drug coverage when I turned 65.</p>	<p>You may be eligible for a special enrollment period to leave your Medicare Advantage plan to return to Original Medicare and join a prescription drug plan. Please keep in mind that it is up to the plan to verify your information and work with Medicare to confirm your enrollment. Your plan may contact you for more information.</p>
<p>15. I am no longer eligible for extra help</p>	<p>Since you are no longer eligible for the extra help, you get a</p>

<p>paying for my Medicare prescription drugs.</p>	<p>special enrollment period to switch to another plan or disenroll. The special enrollment period starts on January 1 and ends on March 31, OR the month you are notified and 2 months after, whichever occurs later in the calendar year.</p>
<p>16. I am disenrolling from a Medicare cost plan and had Medicare prescription drug coverage from the Medicare cost plan.</p>	<p>You may enroll in a Medicare prescription drug plan beginning the month you request disenrollment from the cost plan until the date you request enrollment in a new plan or the last day of the second month following your disenrollment date, whichever is earlier.</p>
<p>17. I am being disenrolled from a Medicare special needs plan because I no longer have special needs status.</p>	<p>If you are no longer eligible for the special needs plan because you no longer meet the specific special needs status, you can request enrollment in a Medicare Advantage or Medicare Part D plan beginning the month your special needs status changes and ending either when you make an election or three months after your plan’s grace period ends, whichever is earlier.</p>
<p>18*. I recently lost Medicare Part B but I still have Part A.</p>	<p>You are only required to have Medicare Part A or Part B to be enrolled in a Medicare Part D plan. If you have lost Part B but still have Part A, you will be disenrolled from a Medicare Advantage plan, even one with a Part D prescription benefit. However, you can choose to join a Medicare drug plan that only covers prescription drugs (that is, one that does not cover medical benefits such as hospital stays or visits to the doctor’s office).</p>
<p>19*. I have had Medicare prior to now, but am now turning 65.</p>	<p>Individuals who had Medicare prior to age 65 (such as, for a disability) have another opportunity to choose a Part D plan upon reaching age 65. If you have been enrolled in Medicare before now but are now turning 65, you have an opportunity to select a new Medicare Drug plan or a Medicare Advantage plan with a Part D prescription drug benefit.</p>
<p>*Only eligible for a Special Election Period for Medicare Part D.</p>	

Medicare Late Enrollment Penalty

If you do not enroll in Medicare Part B (medical insurance) and/or Medicare Part D (prescription drug insurance) when you first become eligible and you (or your spouse) do not have Medical insurance from an employer or union or another credible source, you will be charged a late enrollment penalty. In addition, the longer you wait to enroll in Medicare Part B and Part D, the more significant the penalty.

MediGap Insurance Enrollment

Once you turn 65 and enroll in Medicare Part B, you can sign up for any of the ten Medigap plans (A-N) during a six month open enrollment period. Once you are enrolled, the Medigap insurer must renew your policy for life, as long as you pay your premiums. If you miss a premium payment, you may risk losing your coverage.

Under federal law, once your open enrollment period ends, Medigap insurers can refuse to offer you a Medigap plan because of your health status (non guaranteed issue). However, you may have special protections if you want to buy Medigap because of specific enrollment conditions.

An insurance company can't refuse to sell you a Medigap policy in the following situations:

Scenario	You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
1.	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.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
2.	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. Note: In this situation, you may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
3.	You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. You can keep your Medigap policy, or you may want to switch to another Medigap policy.	Medigap Plan A, B, C, F, K, or L that is sold by any insurance company in your state or the state you are moving to.	As early as 60 calendar days before the date your Medicare SELECT coverage will end, but no later than 63 calendar days after your Medicare SELECT coverage ends.
4.	(Trial Right) You joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare	Any Medigap policy that is sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.

	Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare .		Note: Your rights may last for an extra 12 months under certain circumstances.
5.	(Trial Right) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you have been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If it included drug coverage, you can still get that same policy, but without the drug coverage. If your former Medigap policy isn't available, you can buy Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	As early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. Note: Your rights may last for an extra 12 months under certain circumstances.
6.	Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.
7.	You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	No later than 63 calendar days from the date your coverage ends.

Medicare Eligibility

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States. Medicare covered employment means that you or your employer withheld Medicare taxes from your paycheck for at least 10 years. If you are not yet 65, you still may qualify for coverage if you have a disability or End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

Here are some simple guidelines. You can get Part A at age 65 without having to pay premiums if:

- You already receive retirement benefits from Social Security or the Railroad Retirement Board.
- You are eligible to receive Social Security or Railroad benefits but haven't yet filed for them.
- You or your spouse had Medicare-covered government employment.

If you haven't paid Medicare taxes through your employment (Medicare-covered employment) or meet these other conditions, you will have to pay a Medicare Part A premium. The premium amounts are as follows:

- You paid Medicare taxes for 10 years or more (40 quarters) – \$0.00 per month.
- You paid Medicare taxes for more than 7.5 years but less than 10 years (30 to 39 quarters) – \$254.00 per month.
- You paid Medicare taxes for less than 7.5 years (less than 30 quarters) – \$461.00 per month.

If you are under 65, you can get Part A without having to pay premiums if you have:

- Received Social Security or Railroad Retirement Board (RRB) disability benefits for 24 months.
- End-Stage Renal Disease and meet certain requirements.

If you are close to age 65 and not getting Social Security benefits, you must apply for Medicare. You can apply by calling or visiting your local Social Security office, or by calling Social Security at 1-800-772-1213. You should apply three months before the month you turn 65.

While you don't have to pay a premium for a Part A if you meet one of qualifying requirements, you must pay for Medicare Part B. The Part B monthly premium in 2011 is \$96.40. It is typically deducted from your Social Security, Railroad Retirement, or Civil Service Retirement check. If you don't get any of these payments, Medicare sends you a bill for your Part B premium every 3 months. Newly eligible Medicare beneficiaries in 2011 will have a base premium of \$115.40

If you make higher than a certain level of income per year, you will be required to pay a higher Medicare Part B premium.

2011 Medicare Part B Premiums

You Pay	If Your Yearly Income is	
	Single	Married Couple
\$96.40	\$85,000 or less	\$170,000 or less
(\$115.40 for 2011 eligibles)		
\$154.70	\$85,001 - \$107,000	\$170,001 - \$214,000
\$221.00	\$107,001 - \$160,000	\$214,001 - \$320,000
\$287.30	\$160,001 - \$213,000	\$320,001 - \$428,000
\$353.60	Above \$213,000	Above \$428,000
You Pay	If You Are Married but You File a Separate Tax Return From Your Spouse and Your Yearly Income is:	
\$96.40	\$85,000 or less	
\$287.30	\$85,001 - \$129,000	
\$353.60	Above \$129,000	

Note: You will be eligible for Medicare when you turn 65 even if you are not eligible for Social Security retirement benefits.

Medicare Eligibility – under the age of 65:

If you are under the age of 65, you still may be eligible to receive Medicare benefits. To qualify for Medicare if you are under the age of 65, you must meet one of the following requirements:

- Permanently disabled and have received Social Security disability insurance payments for at least 2 years.
- Receive continuing dialysis for end-stage renal disease (kidney failure) or need a kidney transplant.
- Have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

Medicare Costs

Depending on the type of Medicare insurance you select, your Medicare costs may vary greatly. For some, Original Medicare with a Medicare Part D and Medigap plan provides the most coverage. For others, an all-in-one Medicare Advantage plan, which includes hospital, medical and prescription drug coverage through a private insurance company, is a better value. The overview of the Medicare costs below will help you understand which plan may be best for you.

Medicare Part A (Hospital Insurance)

Premium – as long as you or your spouse paid Medicare taxes for more than ten years, the Medicare Part A premium is free.

If you or your spouse did not pay Medicare taxes, then your Part A premium will be the following:

- **\$254/month** – paid Medicare taxes for less than 10 years but more than 7.5 years.
- **\$461/month** – paid Medicare taxes for less than 7.5 years

Out of Pocket Costs (Hospital Services):

Hospital Stay	Your cost	Notes
Days: 1 – 60	\$1,132.00 deductible	The deductible is not an annual deductible but rather a deductible for each hospital stay as long as the hospital stay doesn't happen 60 days from your last hospital stay.
Days: 61 – 90	\$283.00 per day	
Days: 91 – 150	\$566.00 per day	
Days: 150+	No coverage	After 150 days in the hospital, the Medicare beneficiary is required to pay the full hospital costs.

Skilled Nursing Facility (SNF)

Hospital Stay	Your cost	Notes
Days: 1 – 20	\$0.00	The first 20 days in a Skilled Nursing Facility are paid for by Medicare.
Days: 21 – 100	\$141.50 per day	
Days: 100+	No coverage	After 100 days in a skilled nursing facility, you are required to pay the full healthcare costs.

Out Of Pocket Costs (Home Health) – there are no copays, coinsurance, or deductibles for home healthcare, but you are required to meet a number of guidelines in order to be eligible to receive home healthcare.

Out of Pocket Costs (Hospice) – there are no copays, coinsurance or deductibles for hospice care except for outpatient drugs (\$5 copay) and inpatient respite care (5% coinsurance).

Medicare Part B (Medical Insurance)

Premium – as long as you don’t make more than \$85,000 annually, your monthly premium for Medicare Part B is \$96.40. Newly eligible Medicare beneficiaries in 2011 will have a base premium of \$115.40. If you have higher income your premium will be higher.

2011 Medicare Part B premium table

You Pay	If Your Yearly Income is	
	Single	Married Couple
\$96.40	\$85,000 or less	\$170,000 or less
(\$115.40 for 2011 eligibles)		
\$154.70	\$85,001 - \$107,000	\$170,001 - \$214,000
\$221.00	\$107,001 - \$160,000	\$214,001 - \$320,000
\$287.30	\$160,001 - \$213,000	\$320,001 - \$428,000
\$353.60	Above \$213,000	Above \$428,000
You Pay	If You Are Married but You File a Separate Tax Return From Your Spouse and Your Yearly Income is:	
\$96.40	\$85,000 or less	
\$287.30	\$85,001 - \$129,000	
\$353.60	Above \$129,000	

Out Of Pocket Costs (Medical Services) – for most Part B services, you are required to pay 20% coinsurance after paying the Medicare Part B deductible of \$162.00 per year. Below are a few examples of Medicare Part B covered services and the cost of each. A complete list of these services may be found in the Medicare & You 2011 guide on the Medicare.gov site.

Part B Benefits	Your cost
Doctors’ services	20% coinsurance
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays/ medical equipment	20% coinsurance
Physical, speech and occupational therapy	20% coinsurance
Clinical diagnostic laboratory services	No coinsurance
Home healthcare	No coinsurance
Outpatient mental services	50% coinsurance

Medicare Providers – visiting the correct Medicare providers may also have a large impact on your overall cost. Be sure your doctor accepts Medicare (also known as the Medicare “Assignment”). As long as your provider accepts Medicare, you will pay 20% coinsurance for the specified Part B services. If the provider agrees to see Medicare patients but doesn’t accept the Medicare Assignment, they are able to charge up to

15% more than the Medicare reimbursement rate. If you choose to see this provider, you will be responsible for paying the 15% in addition to the 20% coinsurance amount.

Also, providers may opt out of Medicare at any time. If your provider no longer provides services for Medicare patients, you will be responsible to pay the full cost of the services. If this is the case, prior to delivering medical services, the doctors should notify you that they don't accept Medicare and that you are responsible to pay the full medical bill.

Medicare Part C (Medicare Advantage)

Premium – some Medicare Advantage plans do not collect an additional premium on top of what you are already paying Medicare for your Medicare Part B insurance. If the Medicare Advantage plan does charge a premium, the premium will be in addition to the Part B premium that is deducted monthly from your Social Security check or that you are billed quarterly.

If you choose a Medicare Advantage plan that includes prescription drug insurance, your prescription drug insurance premium will be included in the Medicare Advantage plan premium. If you select a Medicare Advantage plan that does not include prescription drug insurance, you will need to enroll in a Medicare Part D plan separately and pay the Medicare Part D premium. Note: Very few Medicare Advantage plans do not include prescription drug coverage.

Out of Pocket Costs (Hospital, Medical and Prescription Drugs) – depending on whether you purchase a Medicare Advantage HMO, PPO, Private Fee for Service (PFFS) plan or another type of Medicare Advantage plan, your health costs will be different. Below is a table that describes general costs and benefit differences between Medicare Advantage plans.

Basic comparison of 3 most common Medicare Advantage plans

Medicare Advantage Plan Types			
	HMO	PPO	PFFS
Value	Typically least expensive plan; most restrictive doctor and hospital choices.	Typically moderately priced plan; moderately restrictive doctor and hospital choices.	Because of coinsurance, this plan can become expensive but it typically offers the widest selection of doctor and hospital choices.
Doctor & Hospital Network	Most restrictive doctor and hospital network; May only visit doctors, specialists and hospitals on the plan's list except in an emergency.	Moderately restrictive network; May visit any doctor, specialist and hospital in the plan's network. You may also visit doctors, specialists and hospitals outside the network for an additional cost.	Least restrictive network; You may visit any Medicare-approved doctor or hospital that accepts the plan's payment.
General cost of hospital & medical services	You will typically pay a copay each time you visit the doctor or hospital after you have paid your annual deductible.	You will typically pay a coinsurance (a portion of the medical bill) after you have paid your annual deductible.	You will typically pay a coinsurance (a portion of the medical bill) after you have paid your annual deductible.

Medicare Part D (Medicare Prescription Drug Insurance)

Premium – if you purchase a Medicare Part D plan, the average premium in 2011 is \$30.00. For some Part D plans, you may pay a little more than the average premium and with others, you may pay a little less. Also, if you purchase a Medicare Advantage plan with prescription drug coverage, your prescription drug insurance premium will be included in the Medicare Advantage premium. In other words, you will not pay a separate premium for prescription drug coverage if your Medicare Advantage plan includes prescription drug insurance.

Out of Pocket Costs (Prescription Drugs) – As you purchase drugs throughout the year, your drug costs accumulate and your drug payments may change from month to month based on your accumulated drug costs. As you have experienced with other health insurance you may have had, the Part D program has a deductible. Unlike other insurance plans, this prescription drug plan has several parts. Below we have provided a description of each phase based on a standard Medicare Part D plan in 2012:

2012 Standard Medicare Part D plan costs*

Phase	1) Deductible	2) Initial Coverage	3) Coverage Gap (Doughnut Hole)	4) Catastrophic Coverage
Drug Cost:	\$0 - \$320	\$321 - \$2,930	\$2,931 - \$6,657.50	More than \$6,657.50
Insurance Company Pays:	0%	75%	0%	95%
You Pay:	100%	25%	100%	5%

***This table represents the out of pocket costs for a standard 2010 Medicare Part D plan. Depending on the plan you choose, your costs may vary.**

1. Yearly Deductible ("Deductible") – like most insurance programs (auto insurance, health insurance, homeowners insurance), you must pay a deductible before the insurance company begins paying. With Medicare Part D, the deductible is \$320 in 2012. Once you pay \$320, then your insurance begins. Some plans may waive the deductible entirely which would allow you to begin paying only a copay or coinsurance the very first month.

2. Copay or Coinsurance (Initial Coverage) – If your plan has a deductible, once your accumulated drug costs reach the deductible amount, you begin paying a copay or coinsurance. Your copay or coinsurance will depend on whether the drug is a generic drug or a brand drug. Below is an example of what a drug copay schedule might look like on a standard Medicare Part D plan in 2012. Depending on your plan, you might pay a similar amount for your drugs.

Tier	Description	Example Drug Copay
Tier 1	Generic drugs	\$5
Tier 2	Preferred brand drugs	\$25
Tier 3	Other brand drugs	\$40
Tier 4	Specialty drugs	30%

During the Initial Coverage phase, your insurance company is paying roughly 75% of the drug cost and you are paying about 25% of the drug cost. To help you save money, it is recommended that you choose a generic drug if one is available to treat your condition and your doctor has given you permission. If you are able to find a generic drug for each of the drugs you are taking, your monthly copay could be as low as \$5 per drug.

3. Coverage Gap ("Doughnut Hole") – once your total drug costs (both the costs you paid as well as the costs your insurance paid) have exceeded \$2,930 during the calendar year, you will be required to pay 100% of your drug costs up to \$6,657.50. This period is called the Coverage Gap or the Doughnut Hole. If you are taking multiple medications, there is a good chance that you will hit the doughnut hole at some point during the year. It is important to keep in mind that there are things you can do to try to avoid the doughnut hole and to minimize your costs if you do happen to reach the doughnut hole during the year. Here are a few ideas:

a. Avoid reaching the doughnut hole:

- **Use generic drugs:** if you are not already taking generic drugs to treat your condition, speak with your doctor or pharmacist about whether it is safe to treat your condition with a generic drug. Generic drugs, often times, are able to treat your condition just as well as a brand drug, but cost much less. If you can take generic drugs, you will reduce your chance for reaching the doughnut hole and having to pay 100% of your drug costs.

b. What do I do if I hit the doughnut hole?

- **Select a plan that covers generic drugs during the doughnut hole** – if you know that you are probably going to reach the doughnut hole during the year, select a Medicare prescription drug plan that covers your generic drugs during the doughnut hole. By selecting one of these plans, you can continue to pay a low copayment on your generic drugs even during the doughnut hole.
- **Switch to generic drugs** – if you haven't already done so, meet with your doctor or pharmacist and speak with them about switching from brand drugs to generic drugs. This will reduce your drug costs during the doughnut hole.

- **Buy from a pharmacy that offers low cost generic drugs** – in recent years, many pharmacies have been offering generic drugs for \$4 or \$5 for a one month supply. Ask your pharmacy if your generic drugs qualify for the low cost generic drug program.

4. Catastrophic Coverage – once the total drug costs (both the costs you paid as well as the costs your insurance paid) total more than \$6,657.50 during the year, you are eligible for Catastrophic Coverage. During the Catastrophic Coverage phase, you will pay the greater of \$2.50 for generic drugs, \$6.30 for brand name drugs or 5% of your drug cost.

Medigap (Medicare Supplemental Insurance)

Original Medicare (Medicare Part A and Part B) pays for many, but not all, healthcare services and supplies. A Medigap policy, sold by private insurance companies, can help pay some of the healthcare costs (“gaps”) that Original Medicare doesn’t cover, like copays, coinsurance, and deductibles. Keep in mind, Medigap insurance is supplemental and is not required by Medicare. However, many people who have Original Medicare find Medigap plans helpful to offset gaps in the Original Medicare coverage.

Premium – the Medigap premiums vary based on the plan you select (Medigap A – N). The plans with the same letter name offer exactly the same benefits but premiums may be different depending on the insurance company. Medigap is a program where it definitely pays to shop around.

One important factor related to the cost of your Medigap premiums is when you enroll. You will have a 6 month Open Enrollment Period beginning when you turn age 65 and enroll in Medicare Part B to enroll in any Medigap policy offered in your state. If you enroll outside the Open Enrollment Period and you are not eligible for a Medigap Guaranteed Issue right, Medigap plans may use medical underwriting to determine your premium. In addition, the health plans may choose to deny your application entirely. For this reason, if you are interested in a Medigap plan, it is important to enroll in one when you first become eligible.