Module 1:
Understanding Medicare

National Medicare
TRAINING PROGRAM

...helping people with Medicare make informed health care decisions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet
Module 1: Understanding Medicare

Module Description

Original Medicare, Medicare Advantage and Other Medicare Health Plans, and Medicare Prescription Drug Coverage are choices in the Medicare program. This module provides the Medicare "basics" - what Medicare is, your Medicare coverage options, Medicare eligibility, your rights, and how to enroll.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers familiar with the Medicare program, who would like to have prepared information for their presentations.

The following sections are included in this module:

Slides	Topics
2	Objectives
4-42	Program Basics
43-82	Medicare Coverage Choices
83-93	Rights and the Appeals Process
94-103	Programs for People with Limited Income and Resources
103	Information Resources

Objectives

- Recognize the parts of Medicare
- Compare Medicare coverage options
- Relate Medicare-covered services and supplies
- Recognize Medicare rights and appeals
- Explain programs for people with limited income and resources

Target Audience

This comprehensive module is designed for presentation to trainers and other information givers.

Learning Activities

This module contains seven interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

Handouts

Slide 57 is provided as full page handouts as Appendix A. Appendix B is a job aid regarding the Part D Benefit Parameters. Appendix C is the Medicare appeals chart. Appendix D is a chart with detailed information about Medicare Savings Programs. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 105 PowerPoint slides with corresponding speaker's notes. It can be presented in about 2½ hours – 3 hours. Allow approximately 30 more minutes for discussion, questions and answers.

References – See slide 104

Module 1 *Understanding Medicare* explains basics of Medicare, Medigap, and programs to help people with limited income and resources.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Preexisting Condition Insurance Plans (PCIP). The information in this module was correct as of April 2012.

To check for updates on the new health care legislation, visit www.healthcare.gov.

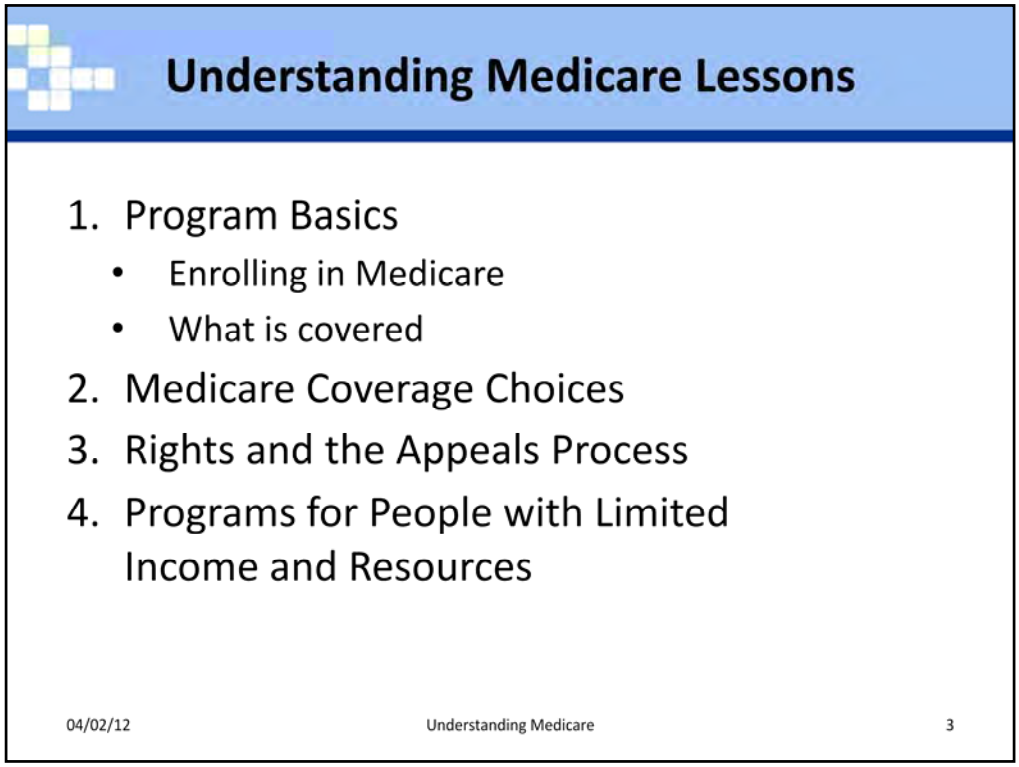
To view the Affordable Care Act, visit www.healthcare.gov/law/full/index.html.

To check for an updated version of this training module, visit http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

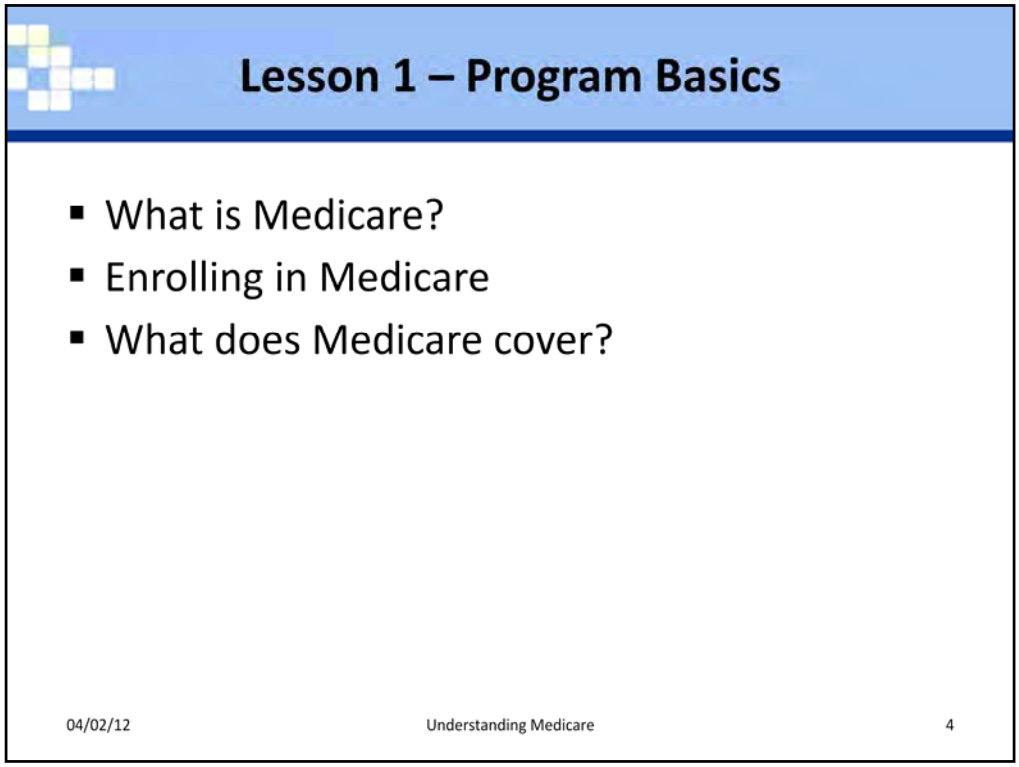
This session will help you to

- Recognize the parts of Medicare
- Compare Medicare coverage options
- Relate Medicare-covered services and supplies
- Recognize Medicare rights and appeals
- Explain programs for people with limited income and resources



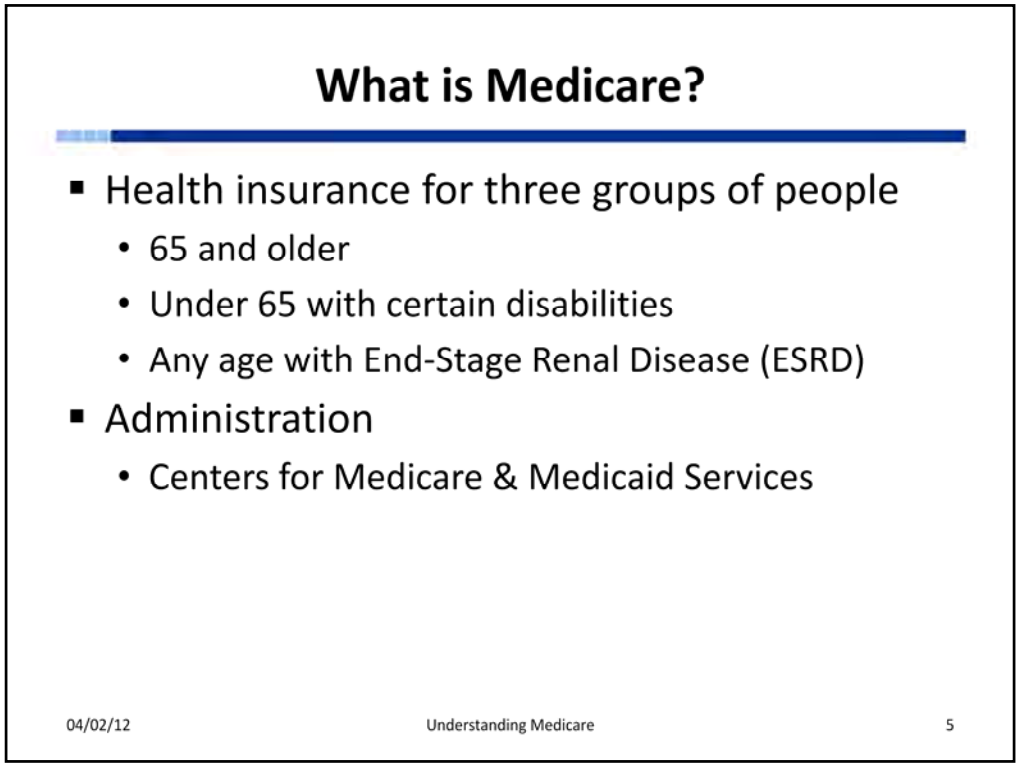
Understanding Medicare is divided into four lessons:

1. Program Basics
2. Medicare Coverage Choices
3. Rights and the Appeals Process
4. Programs for People with Limited Income and Resources



Lesson 1 Program Basics explains

- What is Medicare?
- Enrolling in Medicare
- What does Medicare cover?

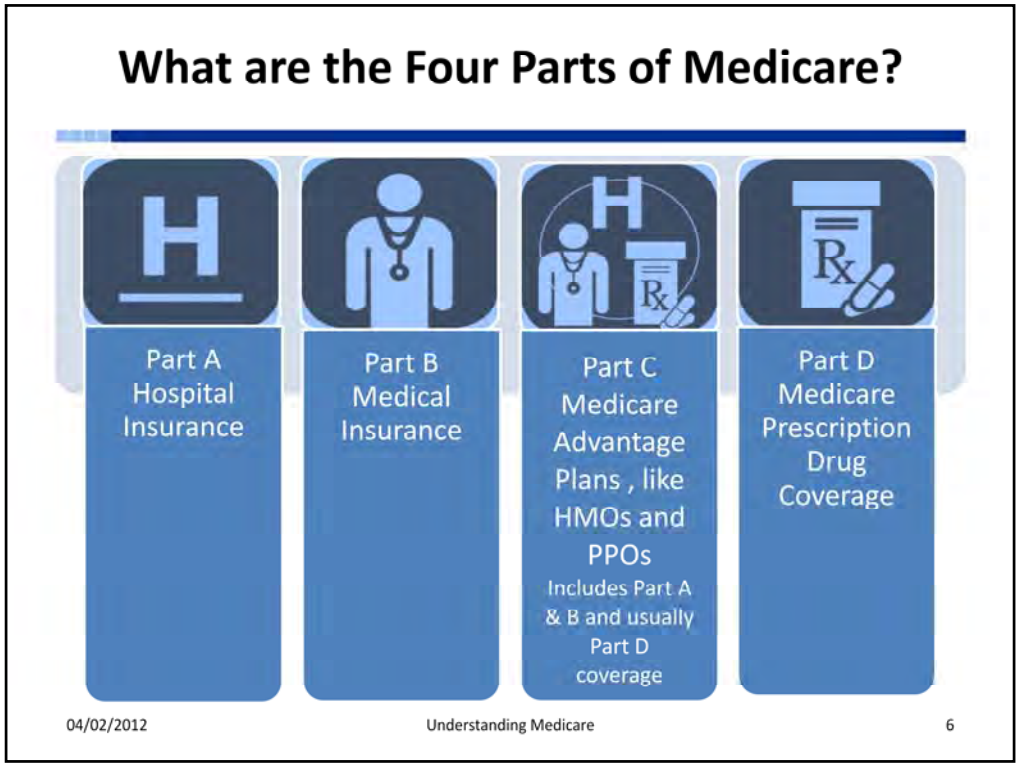


President Lyndon Johnson signed the Medicare and Medicaid programs into law July 30, 1965. Medicaid became effective January 1, 1966, and Medicare became effective July 1, 1966. Medicare is the nation's largest health insurance program, currently covering about 48.6 million Americans.

Medicare is health insurance for three groups of people:

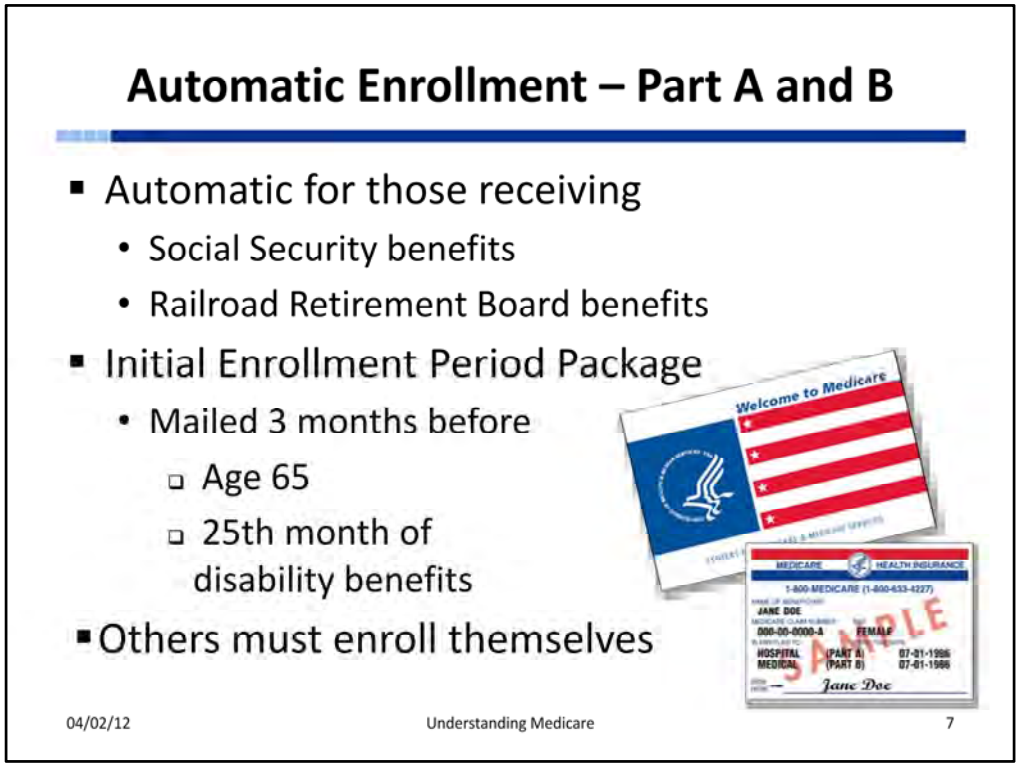
- Those who are age 65 and older
- People under age 65 with certain disabilities who are entitled to Social Security disability or Railroad Retirement benefits for 24 months. The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease). People with ALS get Medicare the first month they are entitled to disability benefits. This provision became effective on July 1, 2001.
- People of any age who have End-Stage Renal Disease (ESRD - permanent kidney failure requiring dialysis or a transplant)

The Centers for Medicare & Medicaid Services administers the Medicare program.



Medicare covers many types of services, and you have options for how you can get your Medicare coverage. Medicare has four parts:

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically-necessary services like doctor visits and outpatient care. Part B also covers some preventive services including screening tests and shots, diagnostic tests, some therapies, and durable medical equipment like wheelchairs and walkers.
- **Part C (Medicare Advantage)** is another way to get your Medicare benefits. It combines Parts A and B, and sometimes Part D (prescription drug coverage). Medicare Advantage Plans are managed by private insurance companies approved by Medicare. These plans must cover medically-necessary services. However, plans can charge different copayments, coinsurance, or deductibles for these services than Original Medicare.
- **Part D (Medicare Prescription Drug Coverage)** helps pay for outpatient prescription drugs and may help lower your prescription drug costs and protect against higher costs in the future.



In most cases, if you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you will automatically get Part A and Part B starting the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.

If you're under 65 and disabled, you automatically get Part A and Part B, after you get disability benefits from Social Security or certain disability benefits from the RRB, for 24 months.

You will get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday (during your Initial Enrollment Period (IEP)), or your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums.

If you have ALS, you automatically get Part A and Part B the month your disability benefits begin.

If you are not getting retirement benefits from Social Security or the Railroad Retirement Board you must enroll yourself to get Medicare. We'll talk about the periods when you can enroll later.

NOTE: If you live in Puerto Rico or a foreign country, and you get benefits from Social Security or the RRB, you will automatically get Part A. If you want Part B, you will need to sign up for it. Residents of Puerto Rico should contact your local Social Security office for more information. Residents of foreign countries can contact any U.S. consular office. You will not receive the IEP package pictured on the slide; you will get a different package.

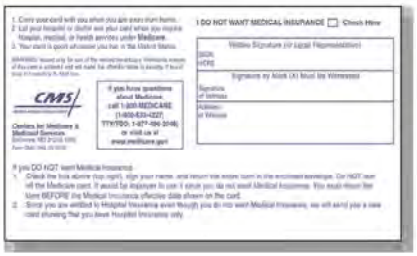
Welcome to Medicare, CMS Product No. 11095, is pictured on this slide. It is part of the IEP Package.

Medicare Card

- Keep it and accept Medicare Parts A and B
- Return it to refuse Part B
  - Follow instructions on back of card

Front

Back



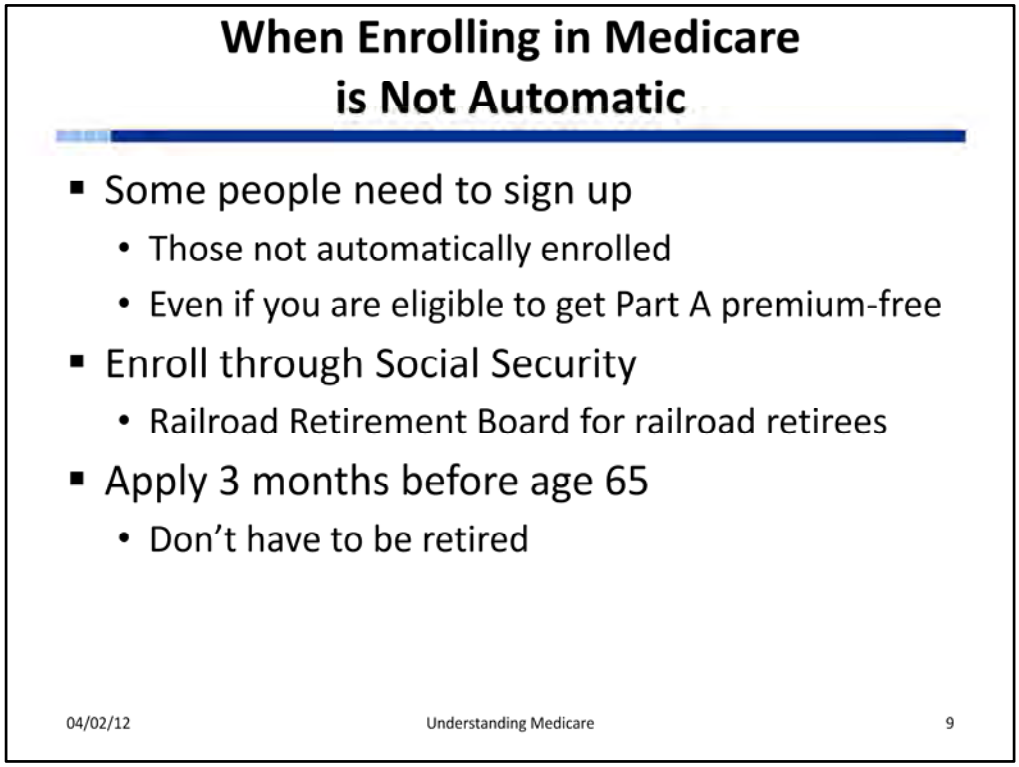
When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care.

This is a sample Medicare card. The Medicare card shows the Medicare coverage (Part A hospital coverage and/or Part B medical coverage) and the date the coverage starts. Note: Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you are related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a B or a D. For railroad retirees, there are numbers and letters in front of the Social Security number. These letters and numbers have nothing to do with having Medicare Part A or Part B.

If you choose another Medicare health plan, your plan may give you a card to use when you get health care services and supplies. You should contact Social Security (or the Railroad Retirement Board if you receive railroad retirement benefits), if any information on the card is incorrect.

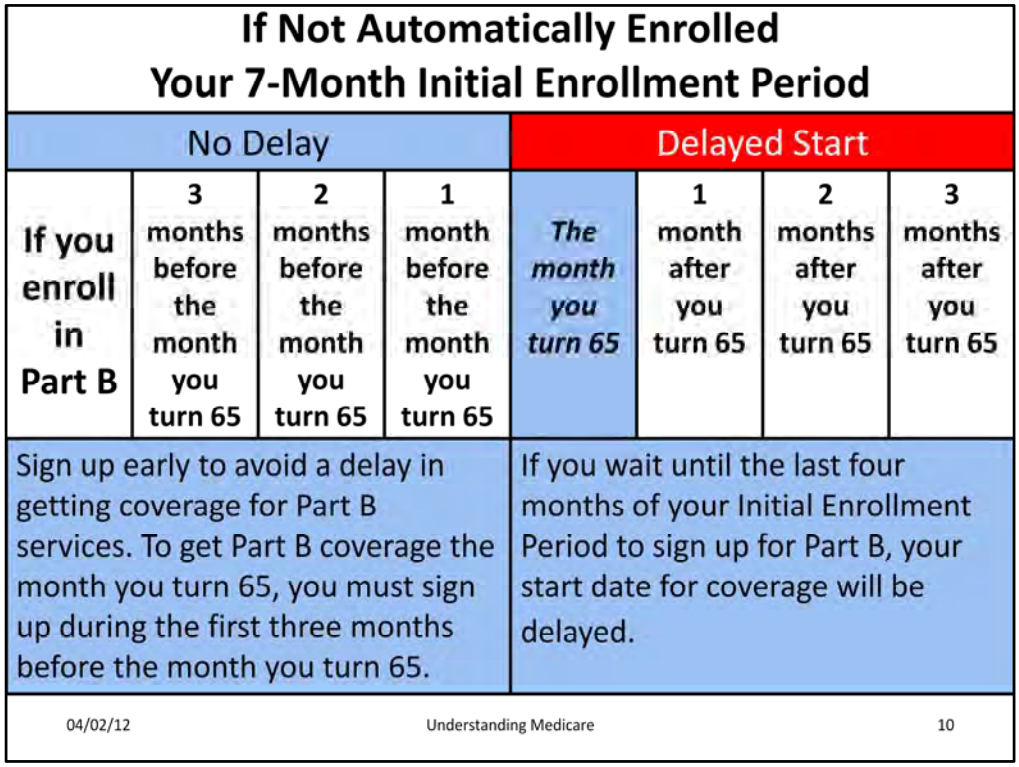
If you don't want Part B, follow the directions and return the card. We will talk more about why you might not want Part B later.



If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits (for instance, because you are still working), you will need to sign up for Part A (even if you are eligible to get it premium-free). You should contact Social Security 3 months before you turn age 65. If you worked for a railroad, contact the RRB to sign up.

While Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA) is responsible for enrolling most people in Medicare. The RRB is responsible for enrolling railroad retirees in Medicare.

Social Security advises people to apply for Medicare benefits 3 months before age 65. You do not have to be retired to get Medicare. The full retirement age for Social Security retirement benefits is now 66 (for persons born between 1943 and 1954) and will gradually increase to 67 for persons born in 1960 or later; but, you can still receive full Medicare benefits at age 65.



If Not Automatically Enrolled
Your 7-Month Initial Enrollment Period

	No Delay			Delayed Start			
If you enroll in Part B	**3 months before the month you turn 65**	**2 months before the month you turn 65**	**1 month before the month you turn 65**	***The month you turn 65***	**1 month after you turn 65**	**2 months after you turn 65**	**3 months after you turn 65**
Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.				If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.			

04/02/12 Understanding Medicare 10

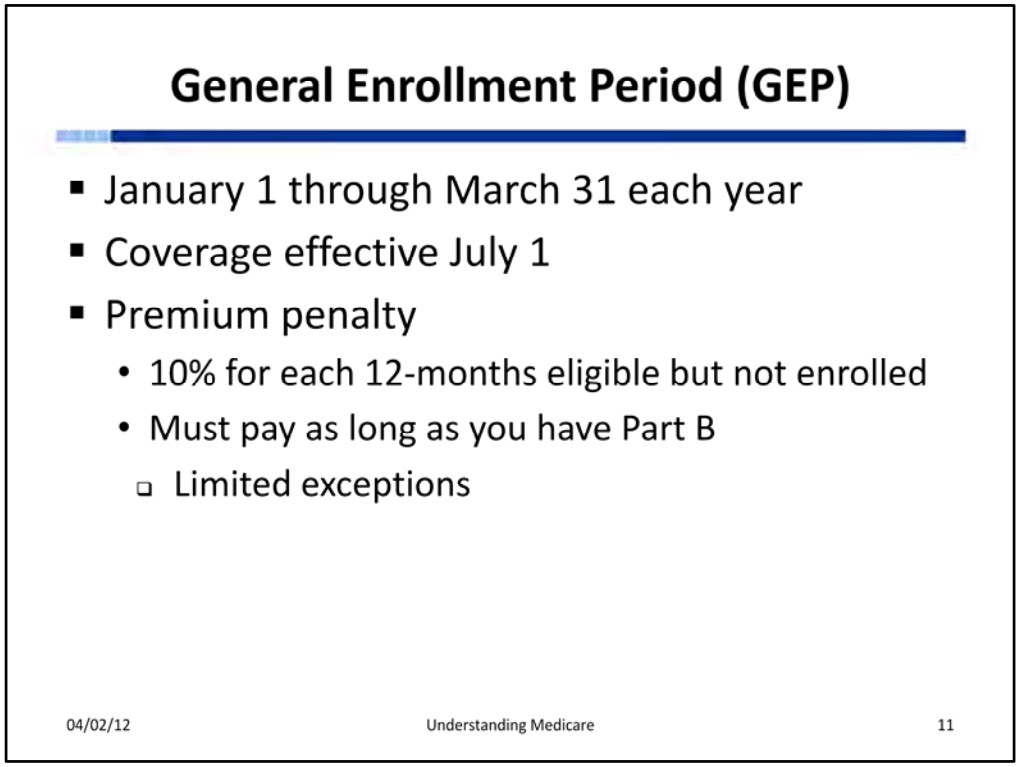
If you are not automatically enrolled, you can choose to sign up for Part B during your Initial Enrollment Period (IEP).

You can sign up for Part B any time during a 7-month IEP which begins 3 months before the month you become eligible for Medicare. You can choose whether or not to enroll in Part B. If you enroll, you pay a monthly premium for Medicare Part B.

Sign up during the first 3 months of your IEP to get your Part B coverage effective the month you turn 65. However, if your birthday is the first day of the month, your coverage will start the first day of the prior month.

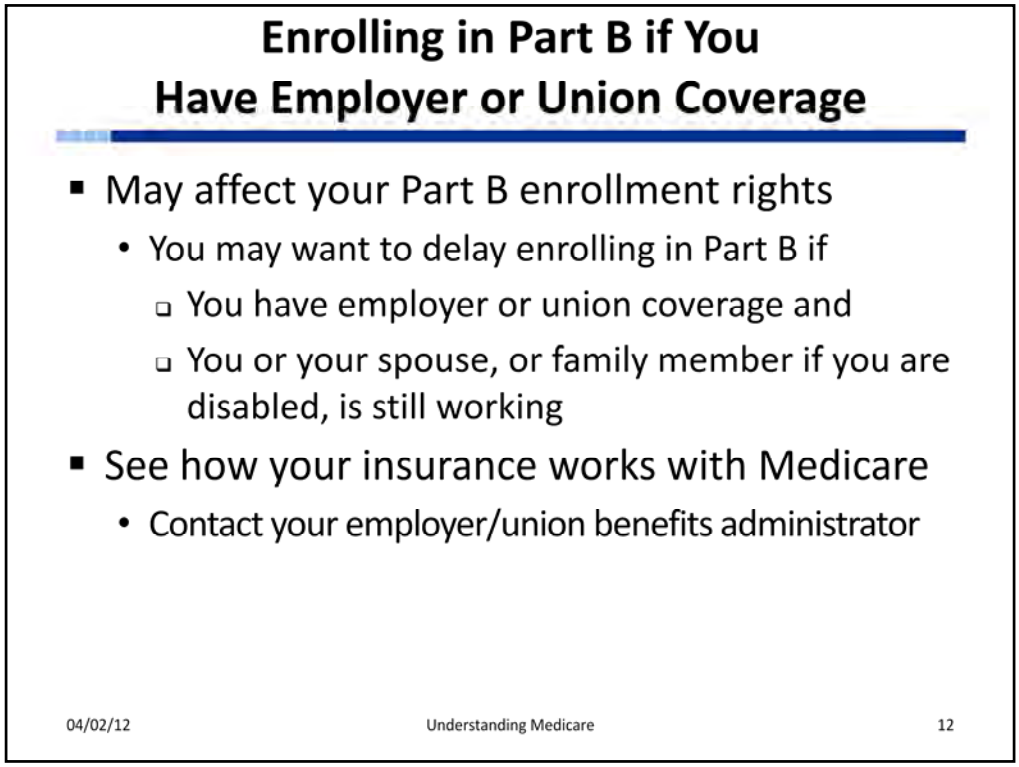
If you wait to sign up until the last four months of your IEP, your Part B start date will be delayed.

NOTE: If your date of birth is the first of the month, your effective date moves to the first of the month before your month of birth, if you apply within the first 2 months of your IEP.



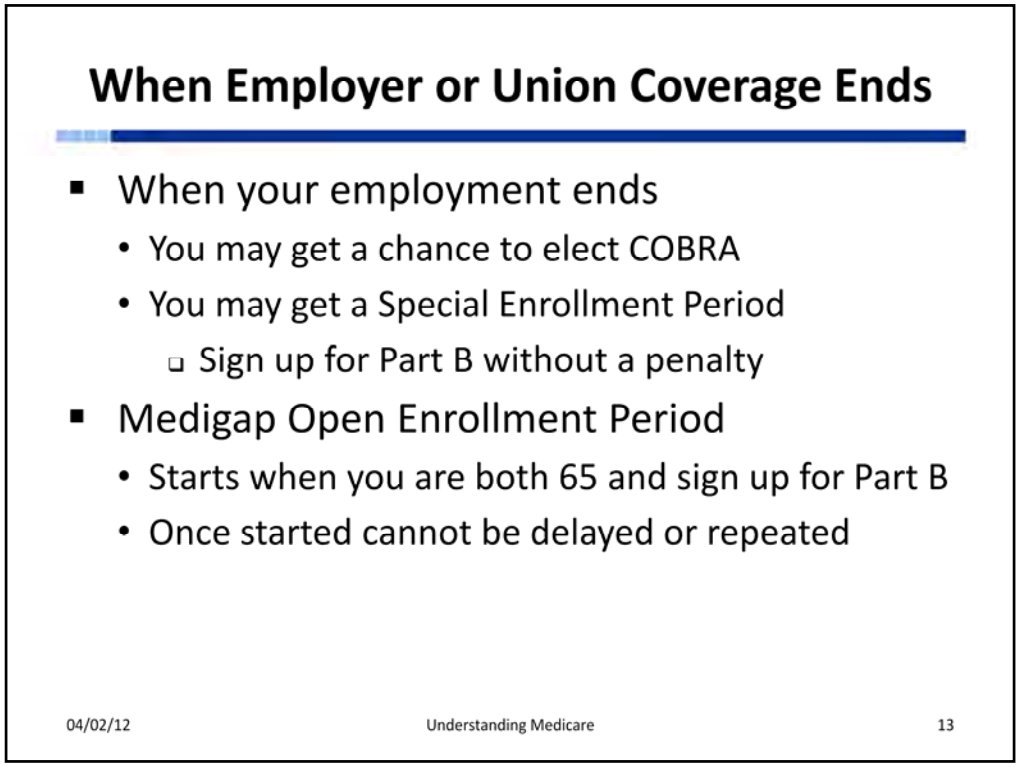
If you don't take Part B when first eligible, you may have to wait to sign up during the annual General Enrollment Period (GEP), which runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.

If you don't take Part B when you are first eligible, you will have to pay a premium penalty of 10% for each full 12-month period you could have had Part B but didn't sign up for it, except in special situations. In most cases, you will have to pay this penalty for as long as you have Part B.



Having coverage through an employer (including the Federal Employee Health Benefits Program) or union while you or your spouse, or family member if you are disabled, is still working, can affect your Part B enrollment rights.

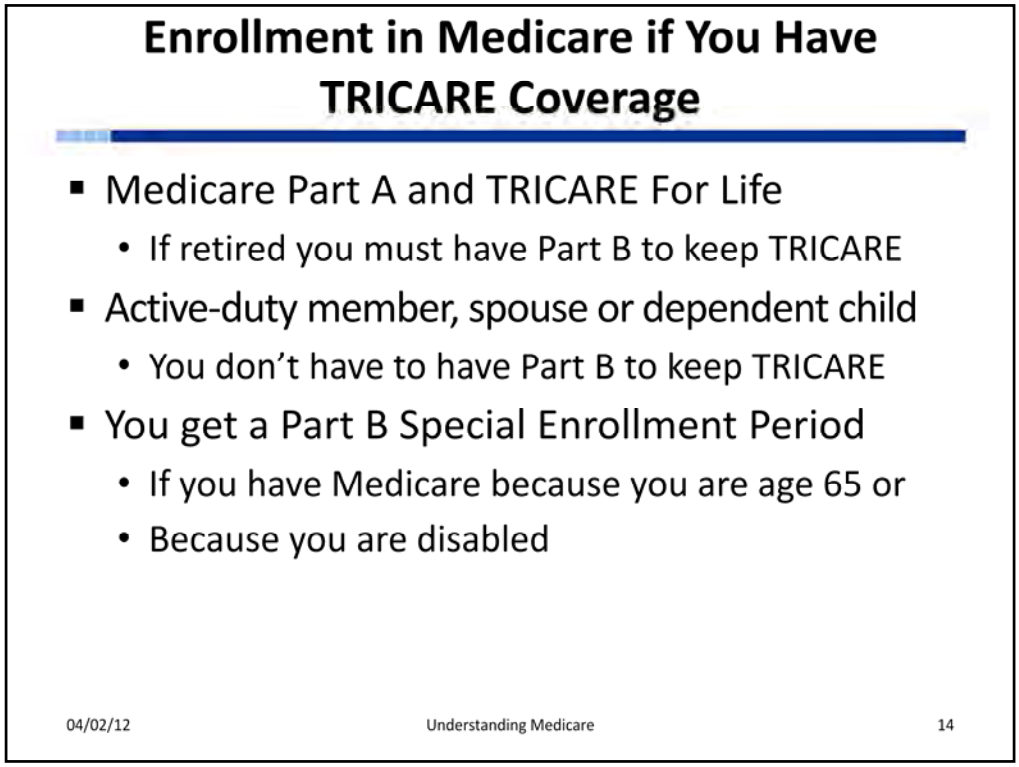
You should contact your employer or union benefits administrator to find out how your insurance works with Medicare, and if it would be to your advantage to delay Part B enrollment.



When your employment ends and you are not enrolled in Part B, certain things can happen:

- You may get a chance to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
- You may get a Special Enrollment Period (SEP) to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month Special Enrollment Period, you may have to pay a late enrollment penalty ***and you will have to wait until the next General Enrollment Period to enroll.***

Medicare doesn't pay all health care costs. One way to cover the costs or "gaps," is to purchase a Medigap policy. We will discuss these in more detail later, but it is important to know that when you sign up for Pa t B, you have a 6-month Medigap Open Enrollment Period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated. Medigap policies are explained on slides 49 – 51.



If you have Medicare Part A and TRICARE (coverage for active-duty military and their family) or TRICARE For Life (coverage for military retirees and their families), you must have Part B to keep your TRICARE coverage.

However, if you are an active-duty service member, or the spouse or dependent child of an active-duty service member, the following applies to you:

- You don't have to enroll in Part B to keep your TRICARE coverage while the service member is on active duty.
- When the active-duty service member retires, you must enroll in Part B to keep your TRICARE coverage.
- You can get Part B during a Special Enrollment Period if you have Medicare because you are age 65 or older, or you are disabled.

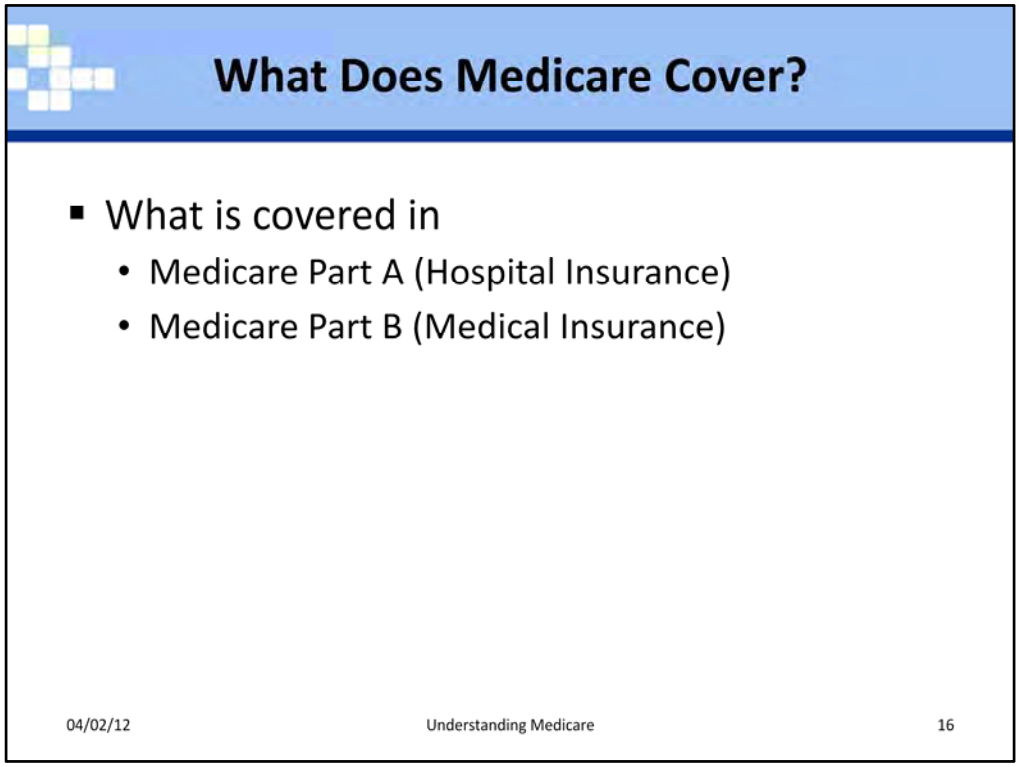
NOTE: If you are in a Medicare Advantage Plan or choose to join a plan, tell the plan that you have TRICARE so your bills can be paid correctly.

Exercise

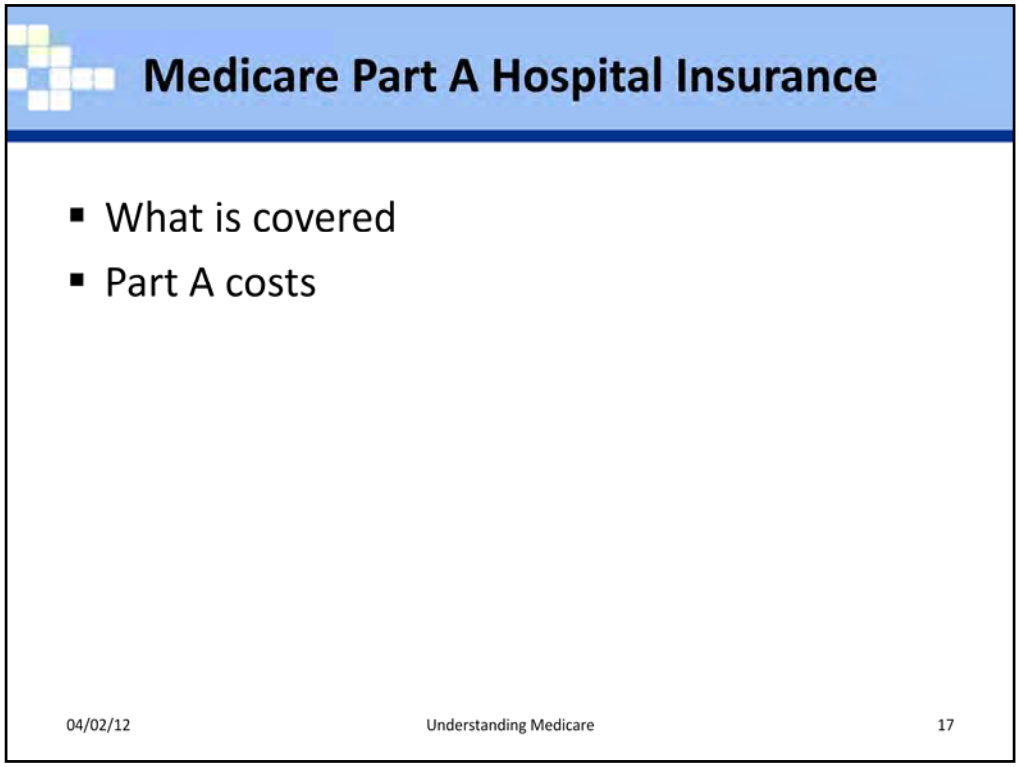
Social Security is responsible for enrolling most people in Medicare.

1. True
2. False

Answer: 2. True
Social Security is responsible for enrolling most people in Medicare.

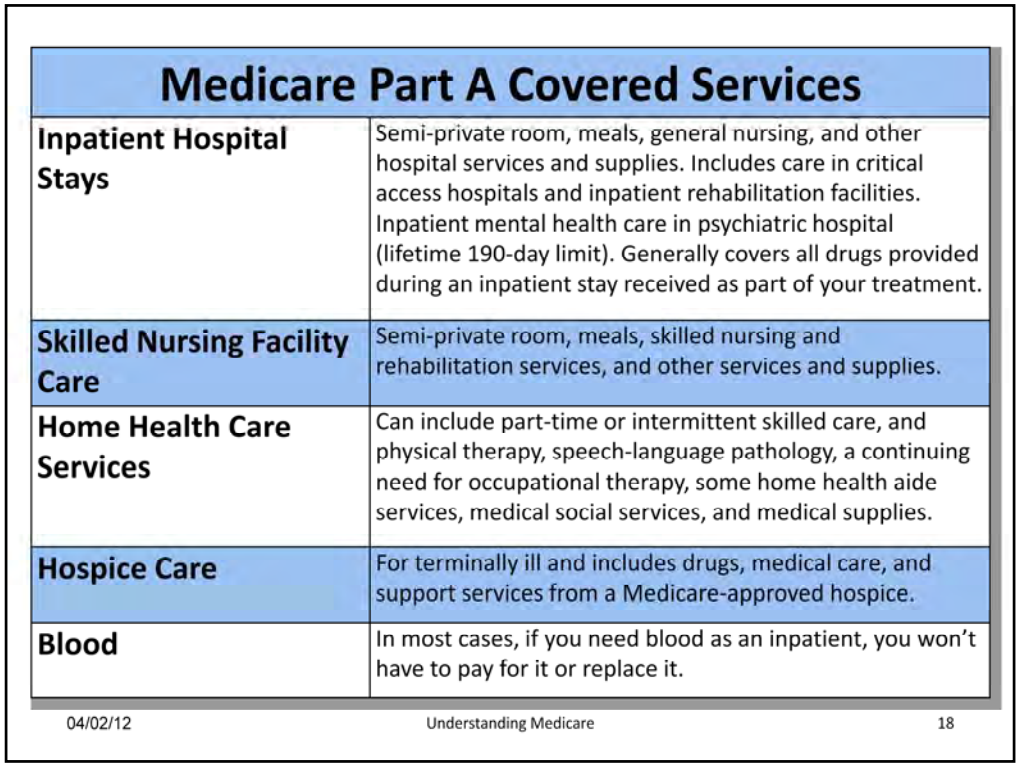


This section explains what is covered by Medicare Part A (Hospital Insurance) and Medicare



Medicare Part A Hospital Insurance explains the following:

- What is covered
- Part A costs



Medicare Part A Covered Services	
Inpatient Hospital Stays	Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital (lifetime 190-day limit). Generally covers all drugs provided during an inpatient stay received as part of your treatment.
Skilled Nursing Facility Care	Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
Home Health Care Services	Can include part-time or intermittent skilled care, and physical therapy, speech-language pathology, a continuing need for occupational therapy, some home health aide services, medical social services, and medical supplies.
Hospice Care	For terminally ill and includes drugs, medical care, and support services from a Medicare-approved hospice.
Blood	In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Medicare Part A, hospital insurance covers medically necessary services.

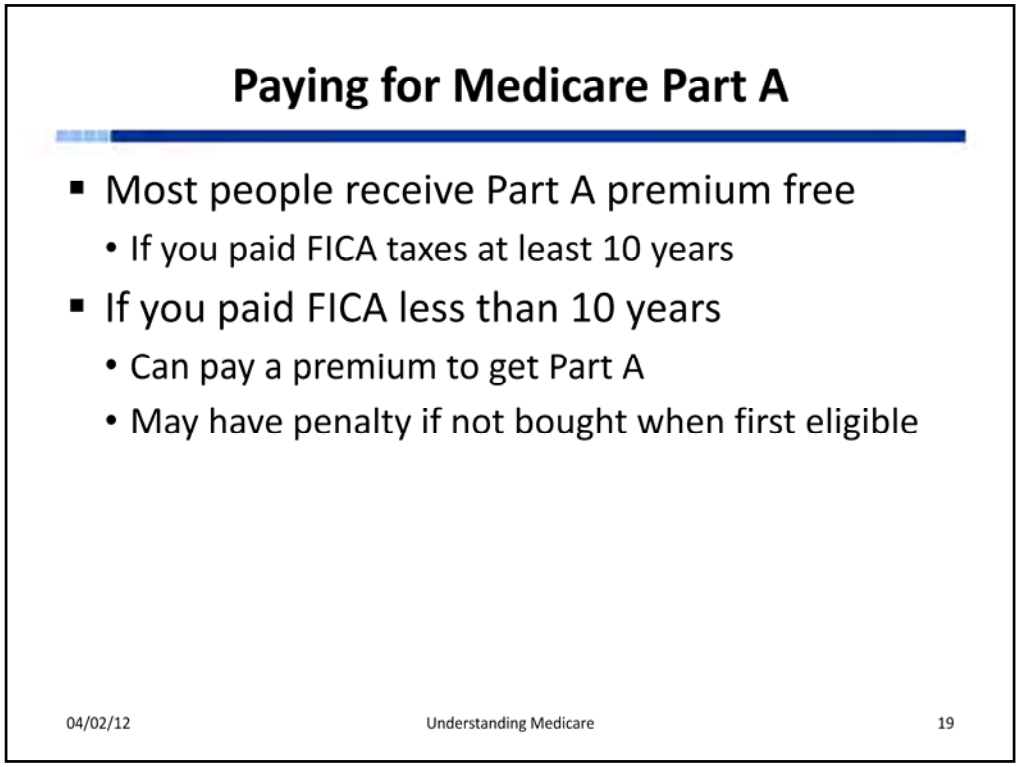
Hospital inpatient care covers - semi-private room, meals, general nursing, and other hospital services and supplies; care in critical access hospitals and inpatient rehabilitation facilities; and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit). Coverage does not include private duty nursing, television or telephone in your room if there are separate charges for these items, and private rooms , unless medically necessary. Generally covers all drugs provided during an inpatient stay received as part of your treatment.

Skilled nursing facility (SNF) care (not custodial or long-term care) – covers semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.

Home health care services – Covers medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, a continuing need for occupational therapy, home health aide services, medical social services, and medical supplies. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. You must be homebound, which means that leaving home is a major effort. You pay nothing for covered home health services.

Hospice Care - For people with a terminal illness. Your doctor must certify that you are expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; and other covered services as well as services Medicare usually doesn't cover, such as grief counseling.

Blood - In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.



Medicare Part A is premium free if you or your spouse paid Medicare or Federal Insurance Contributions Act (FICA) taxes while working (10 year minimum in most cases). FICA funds the Social Security and Medicare programs.

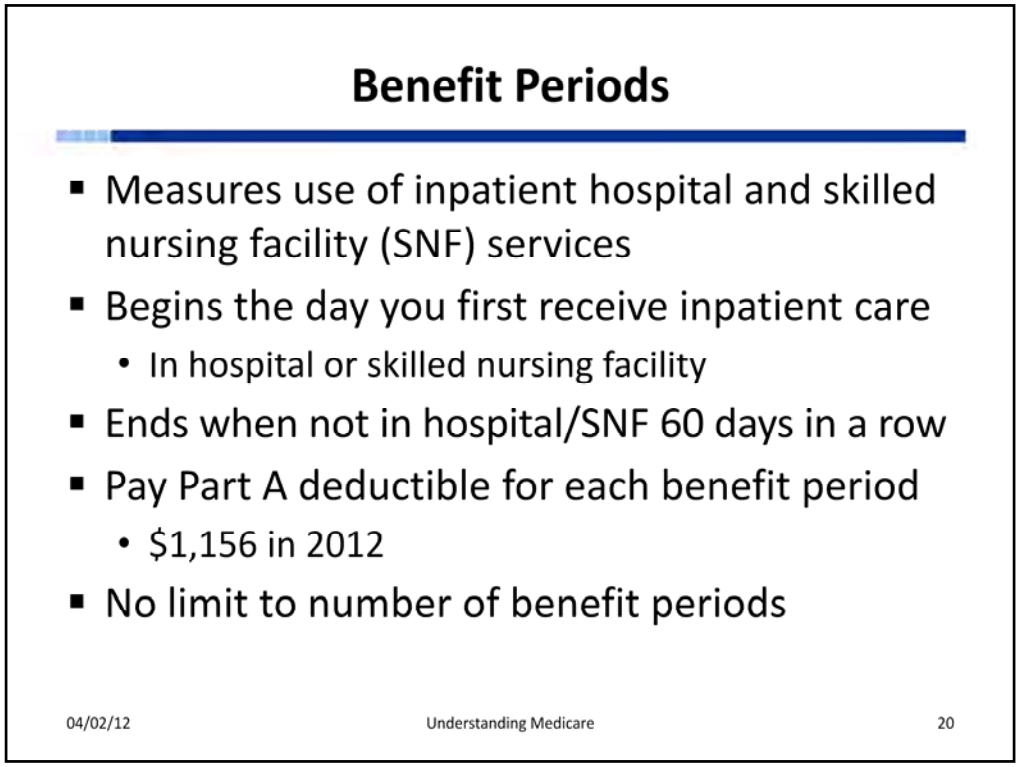
If either you or your spouse doesn't qualify for premium-free Medicare Part A, you may still be able to get Medicare Part A by paying a monthly premium. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

SSA determines if you have to pay a monthly premium for Part A.

In 2012, the Part A monthly premium is $248 (for a person who has worked 30-39 quarters) or $451 (for a person who has worked less than 30 quarters) of Medicare-covered employment.

If you don't buy Medicare Part A when you are first eligible, you may have to pay a monthly premium penalty. The premium is subject to a 10% increase payable for twice the number of full twelve month periods you could have been but were not enrolled. The 10% premium surcharge will apply only after 12 months have elapsed from the last day of the IEP to the last date of the enrollment period you used to enroll. In other words, if it is less than 12 months, the penalty will not apply. *This penalty won't apply to you if you are eligible for a Special Enrollment Period* (anytime that you or your spouse [or family member if you're disabled] are working, and you're covered by a group health plan through the employer or union based on that work or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first).

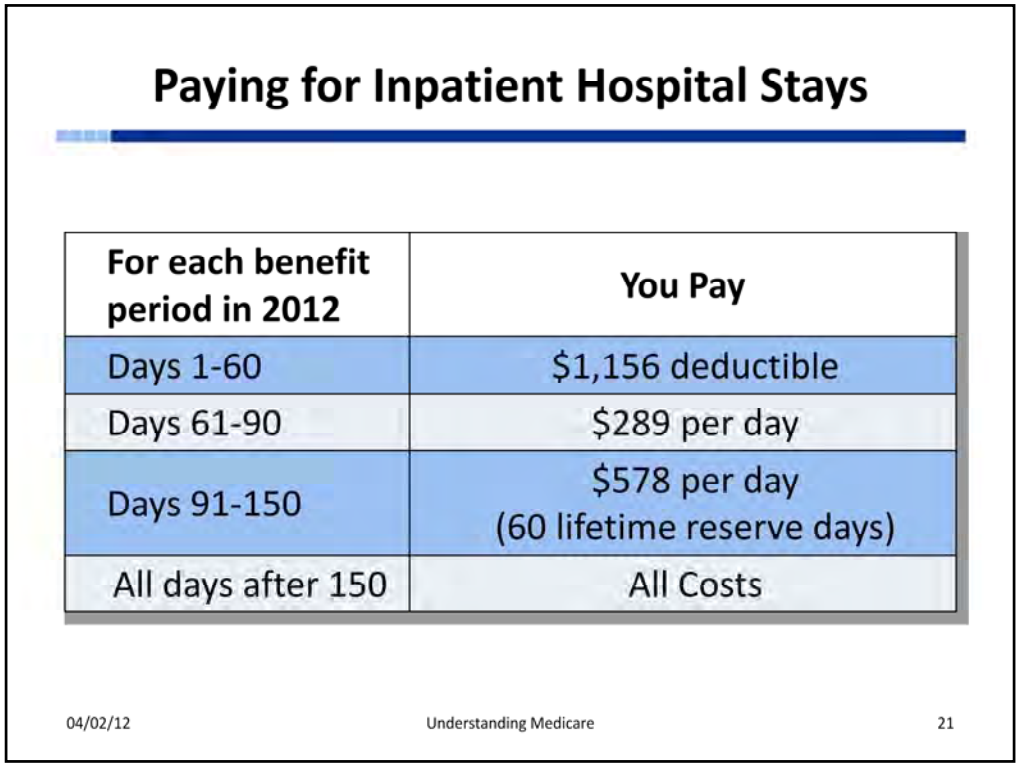
For information on Medicare Part A entitlement, enrollment, or premiums, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.



A benefit period refers to the way Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins on the day you first receive inpatient care in a hospital or skilled nursing facility.

The benefit period ends when you are not in a hospital, or receiving skilled nursing care in a skilled nursing facility, for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible ($1,156 in 2012) for each benefit period. There is no limit to the number of benefit periods you can have.

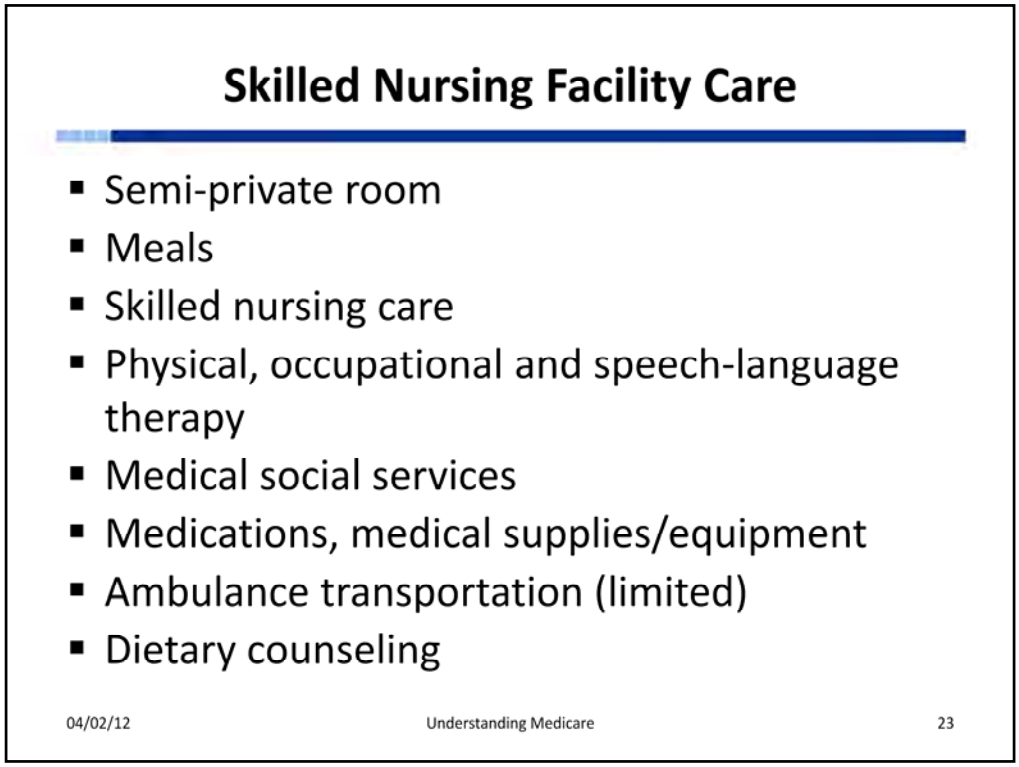


For each benefit period in 2012 you pay

- A total of $1,156 for a hospital stay of 1-60 days
- $289 per day for days 61-90 of a hospital stay
- $578 per day for days 91-150 of a hospital stay (Lifetime Reserve Days). Original Medicare will pay for a total of 60 extra days—called “lifetime reserve days”—when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime.
- All costs for each day beyond 150 days

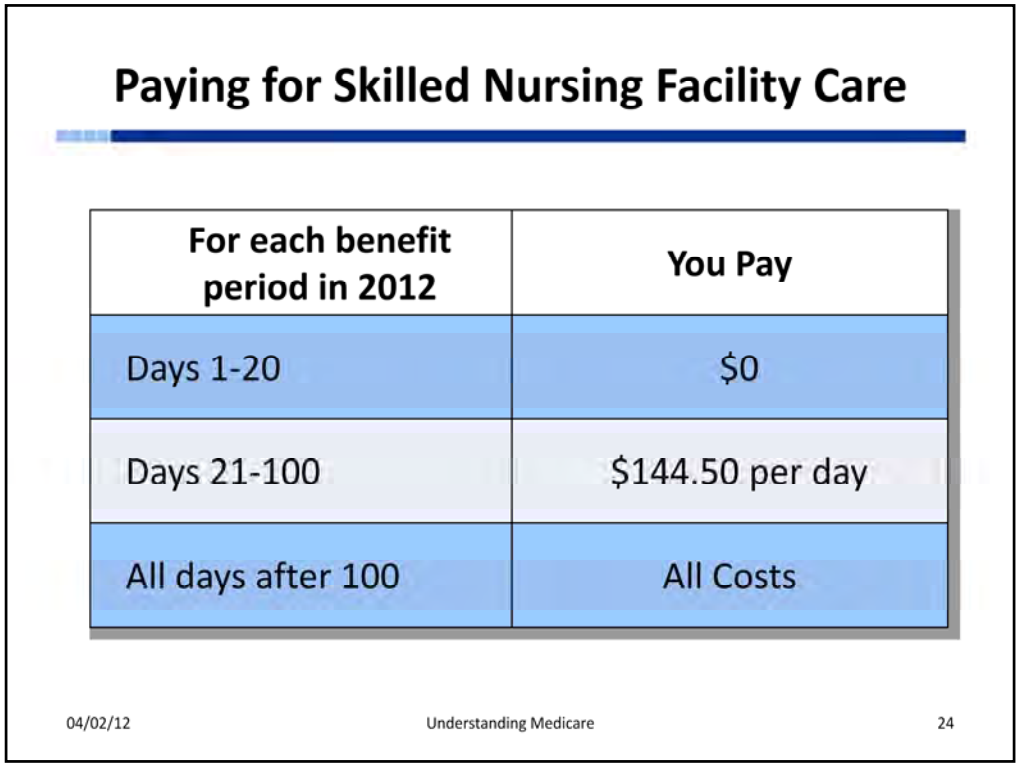
Medicare Part A will pay for skilled nursing facility (SNF) care for people with Medicare who meet all of the following conditions:

- Your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a skilled nursing facility.
- This does not include custodial or long-term care. Medicare doesn't cover custodial care if it is the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
- You were an inpatient in a hospital for three consecutive days or longer (not counting the day you were discharged), before you were admitted to a participating SNF. It's important to **note** that an overnight stay doesn't guarantee that you are an inpatient. An inpatient hospital stay begins the day you are formally admitted with a doctor's order, and doesn't include the day you are discharged.
- You were admitted to the SNF within 30 days after leaving the hospital.
- Your care in the SNF is for a condition that was treated in the hospital or arose while receiving care in the SNF for hospital-treated condition.
- The facility MUST be a Medicare participating SNF.



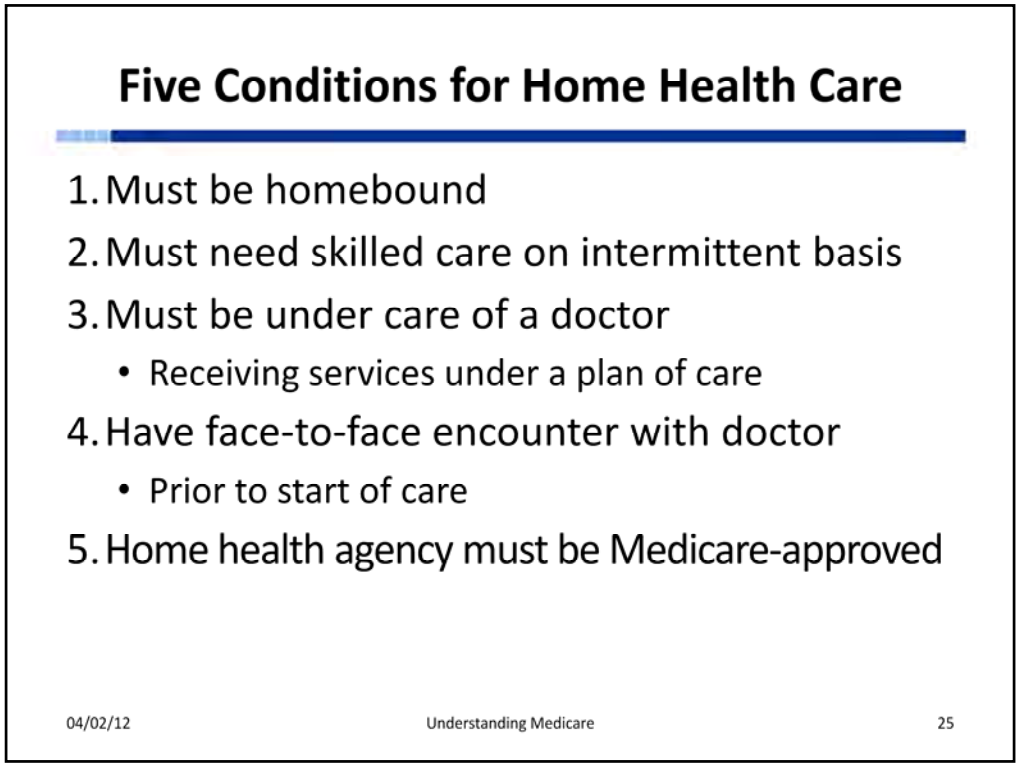
If you qualify, Medicare will cover the following SNF services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications, and medical supplies/equipment used in the facility
- Ambulance transportation, to the nearest supplier of needed services that are not available at the SNF when other transportation endangers health
- Dietary counseling



Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. In 2012, under Original Medicare, days 21 – 100 of SNF care are covered for each benefit period except for coinsurance of up to $144.50 per day. After 100 days, Medicare Part A no longer covers SNF care.

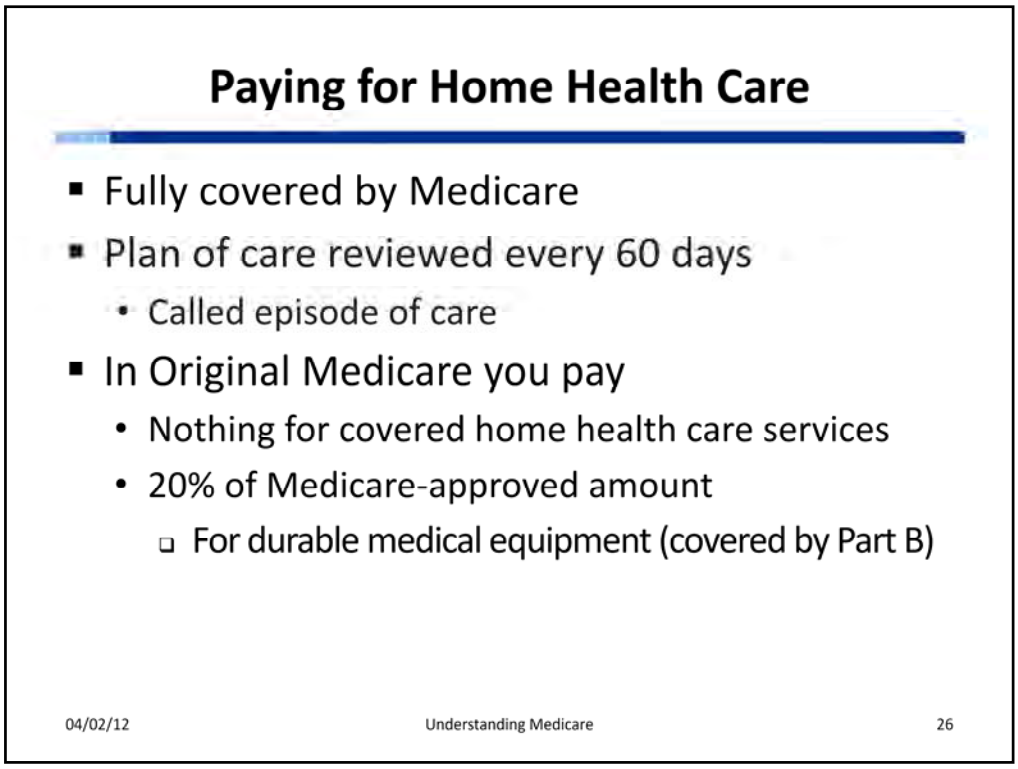
You can qualify for skilled nursing care again every time you have a new benefit period.



To be eligible, you must meet all of these conditions:

1. You must be homebound, which means that you are normally unable to leave home or that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care (may include adult day care) or attend a religious service.
2. You must need skilled care on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
3 Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
4. Prior to certifying a patient's eligibility for the Medicare home health benefit, the doctor must document that the doctor or a non-physician practitioner has had a face-to-face encounter with the patient. Section 6407 of the Affordable Care Act is largely a Medicare provision but it applies to Medicaid in the same manner and to the same extent in the case of doctors authorizing home health services.
   - The encounter must be done up to 90 days prior, or within 30 days after the start of care.
   - Telehealth may be used if provisions are met per 1834(m).
5. The home health agency caring for you must be approved by Medicare.

NOTE: Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay does not precede it, or when the number of Part A-covered home health care visits exceed 100.

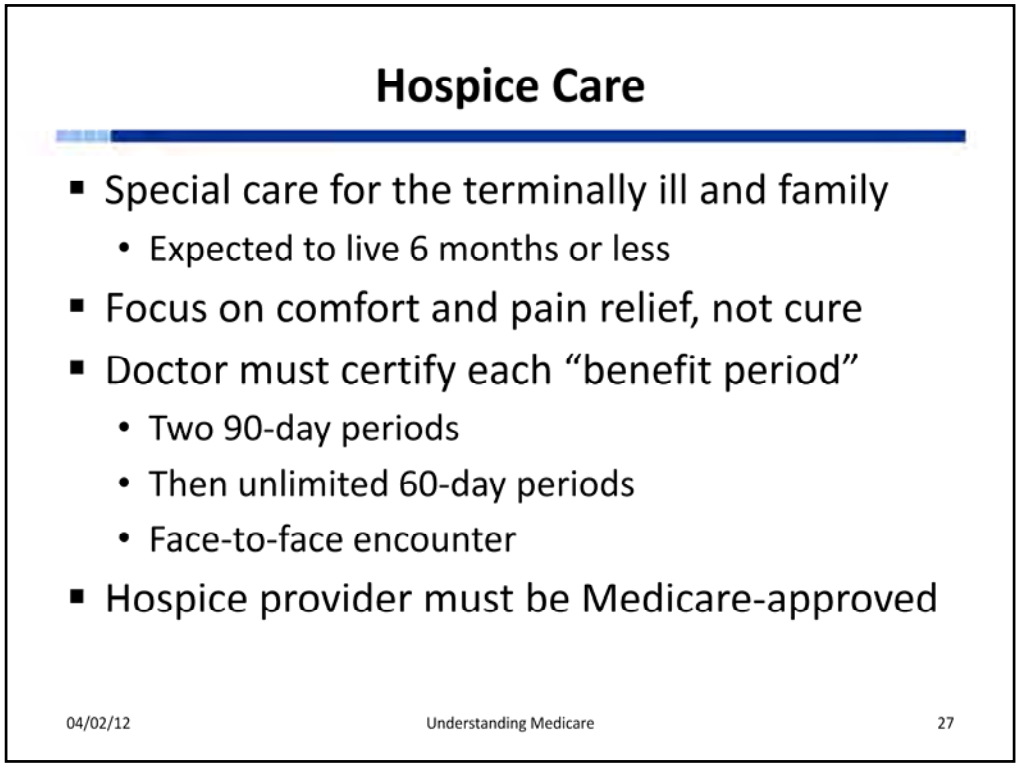


In Original Medicare, for Part A covered home health care, you pay the following:

- Nothing for covered home health care services provided by a Medicare-approved home health agency
- If you have Part B, you pay 20% of the Medicare-approved amount for an assigned durable medical equipment claim. If the claim is non-assigned, the person with Medicare is responsible for whatever the durable medical equipment supplier charges over and above the Medicare-approved amount. (We will discuss assignment later.)

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit does **not** apply to you if you are only enrolled in Part A. If you are enrolled **only** in Part B and qualify for the Medicare home health benefit, then all of your home health services are financed under Part B. There is no 100-visit limit under Part B.

To find a home health agency in your area, call 1-800-MEDICARE or visit www.medicare.gov and use the Home Health Compare tool.



Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You can get hospice care as long as your doctor certifies that you are terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "periods of care"—two 90-day periods followed by unlimited 60-day periods. Per Section 3132 of the Affordable Care Act, Medicare has added a new requirement for hospice face-to-face visits.

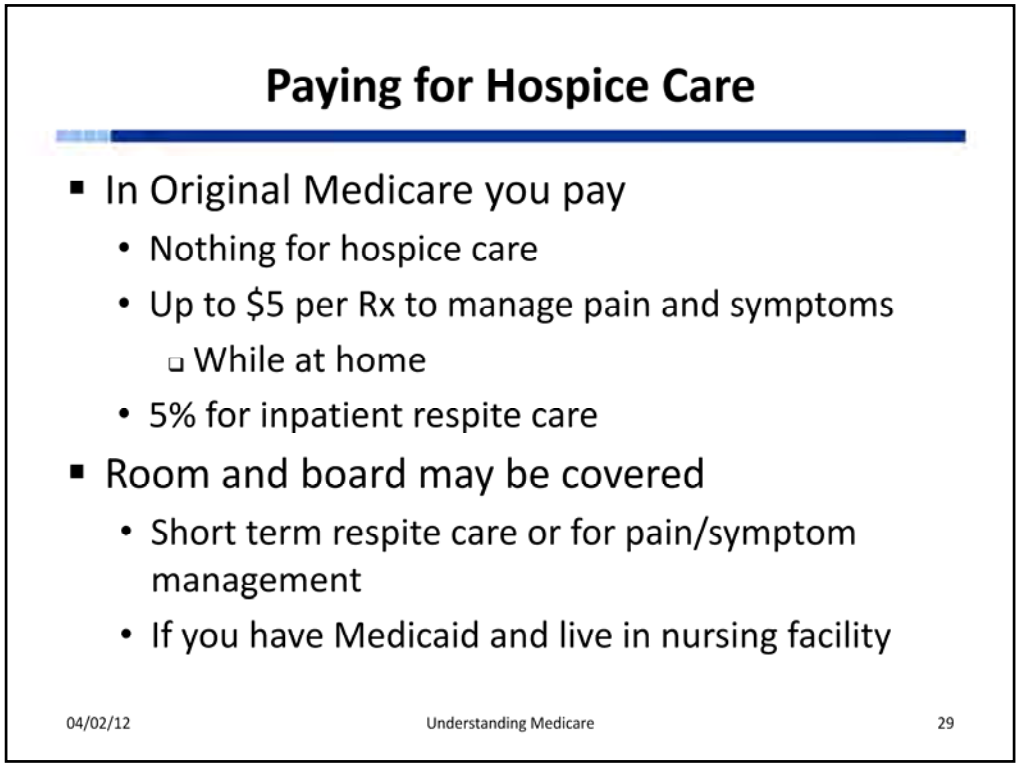
- Requires doctor to meet with patient within 30 days of hospice recertification
- Starting before the third benefit period

You must sign a statement choosing hospice care instead of routine Medicare covered benefits to treat your terminal illness. However, medical services not related to the hospice condition would still be covered by Medicare.

At the start of each benefit period, your doctor must certify that you are terminally ill for you to continue getting hospice care. Medicare must approve the hospice care provider.

The hospice benefit covers many services that are out of the ordinary. In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech therapy, the hospice benefit also covers the following:

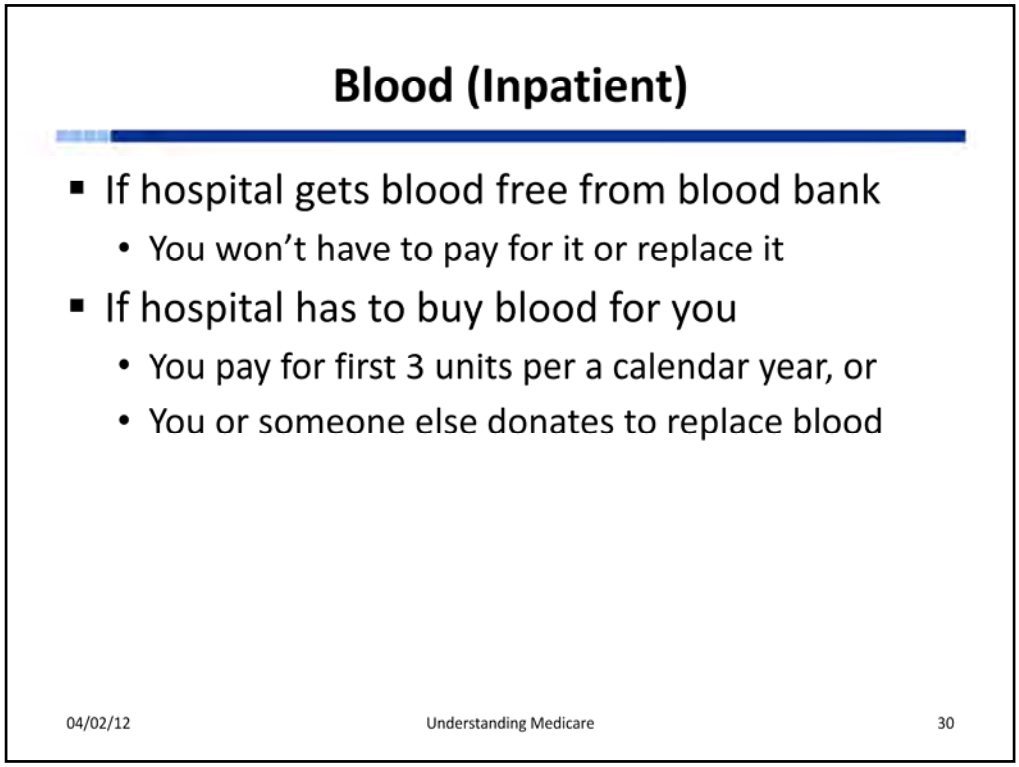
- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control and pain relief
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management
- Inpatient respite care, which is care given to a hospice patient by another caregiver, so the usual caregiver can rest. You will be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there is no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
- Hospice aide and homemaker services
- Social worker services
- Counseling to help you and your family with grief and loss
- Dietary and other counseling



For hospice care in Original Medicare, you pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you will pay $7.50 per day. The amount you pay for respite care can change each year.

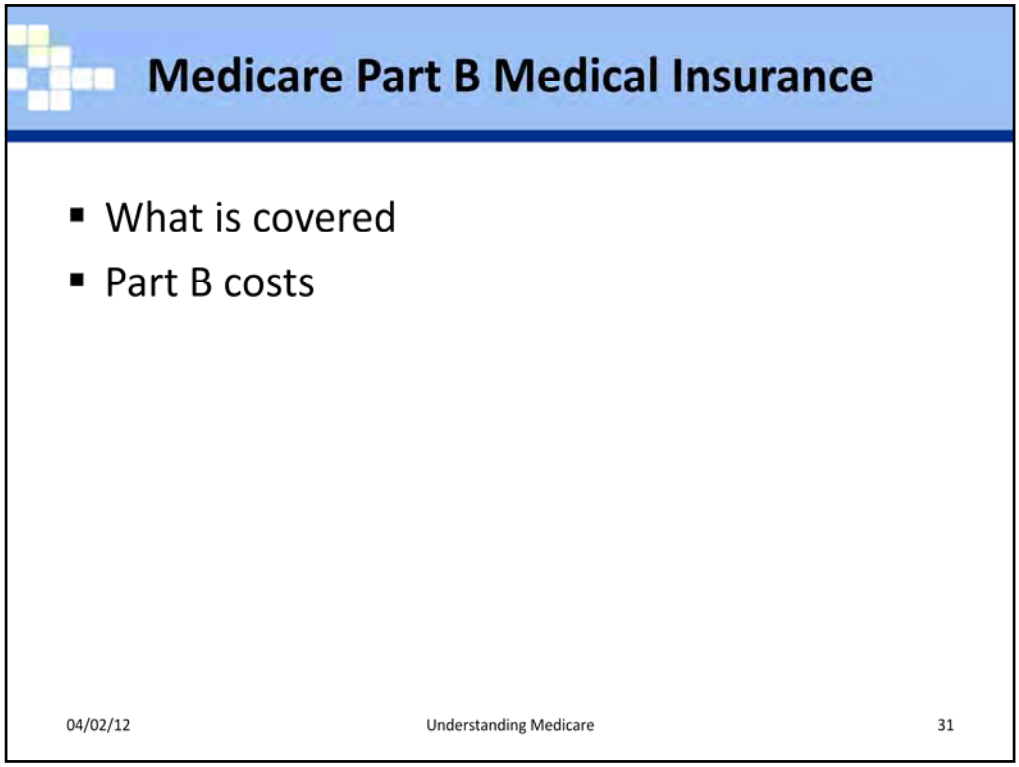
Room and board are only payable by Medicare in certain cases. Room and board are covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board are not covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in an nursing facility, room and board are covered by Medicaid.

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227) or your state hospice organization in the blue pages of your telephone book. TTY users should call 1-877-486-2048.



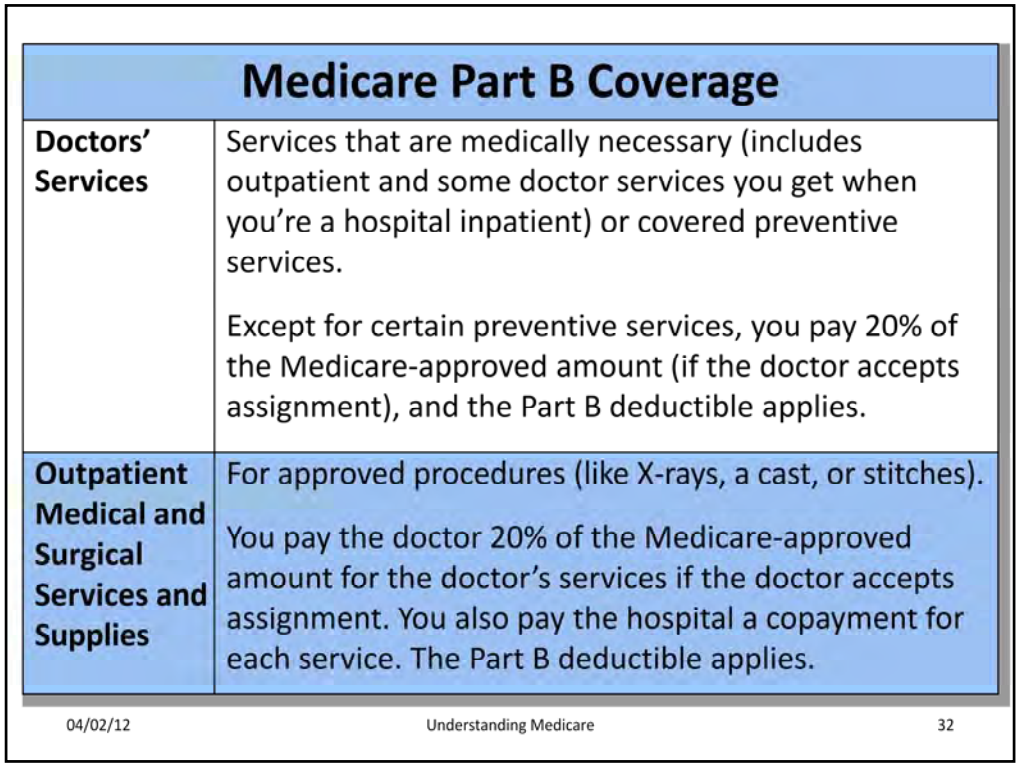
In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it.

If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year, or have the blood donated by you or someone else.



Medicare Part B Medical Insurance explains the following:

- What is covered
- Part B costs



Medicare Part B Coverage	
Doctors' Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies.
Outpatient Medical and Surgical Services and Supplies	For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies.

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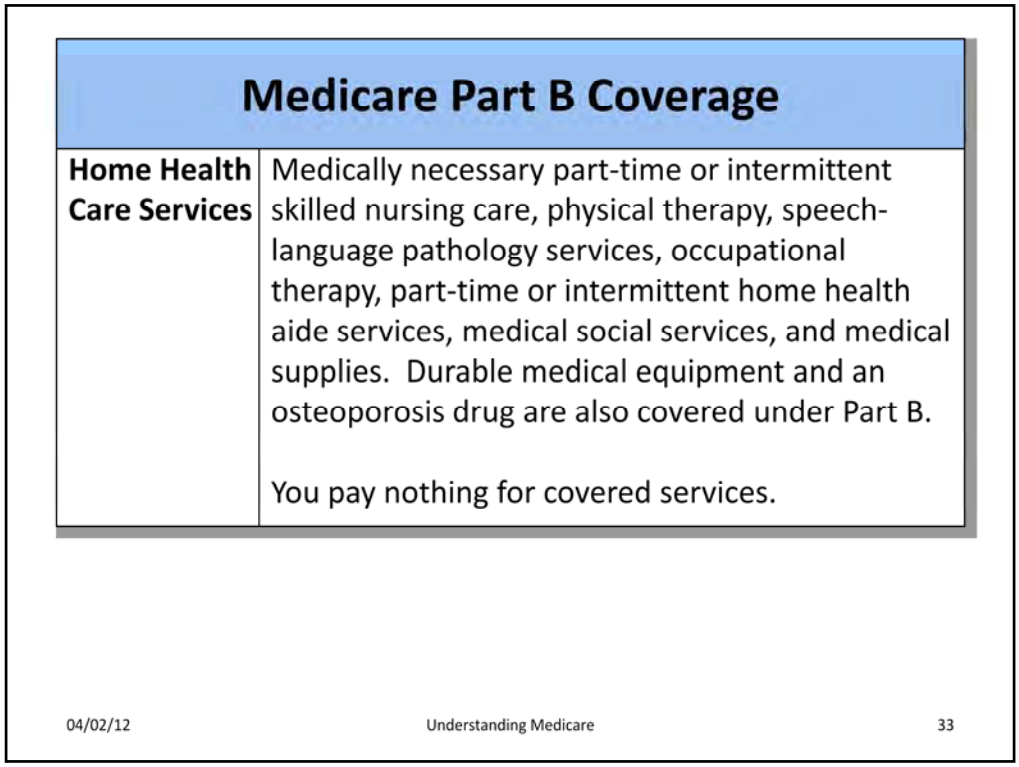
Medicare Part B covers a number of medically-necessary services and supplies. Certain requirements must be met.

Doctors' Services - Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare approved amount, and the Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies - For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services. You also pay the hospital a copayment for each service you get in a hospital outpatient setting. For each service, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.

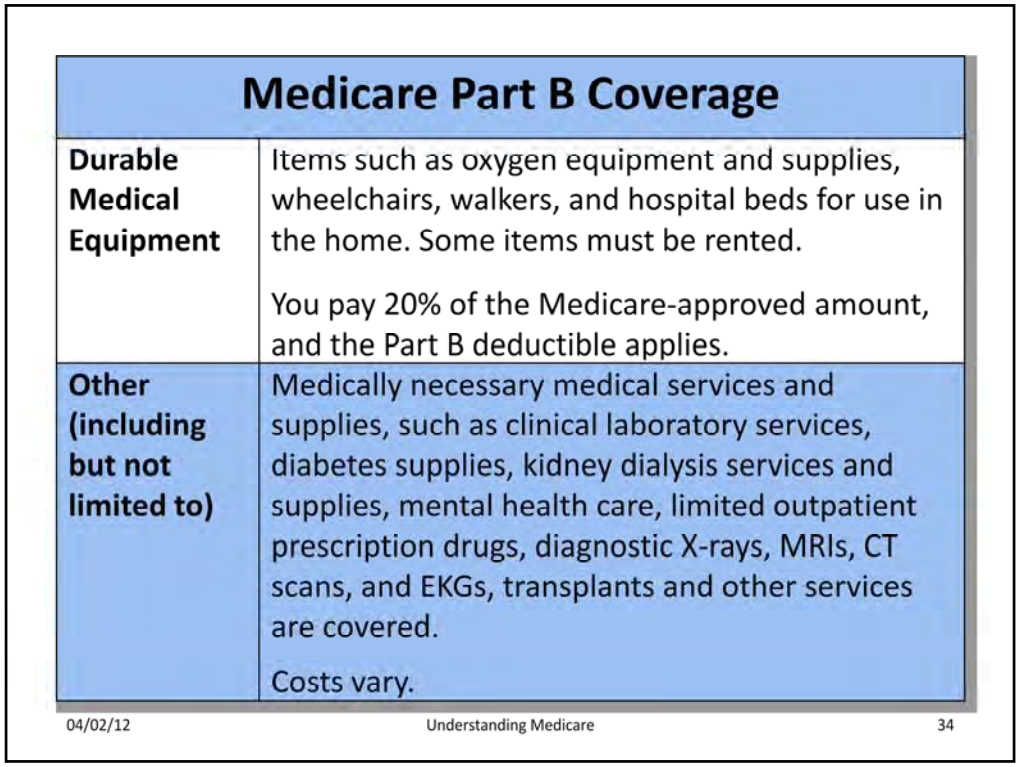
See slides 46 and 47 for information on assignment and the limiting charge.



Medicare Part B covers a number of medically-necessary services and supplies. Certain requirements must be met.

Home Health Care Services – Covers medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, a continuing need for occupational therapy, home health aide services, medical social services, and medical supplies. Durable medical equipment and an osteoporosis drug are also covered under Part B. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. You must be homebound, which means that leaving home is a major effort. You pay nothing for covered home health services.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit does **not** apply if you are only enrolled in Part A. If you are enrolled **only** in Part B and qualify for the Medicare home health benefit, then all of your home health services are financed under Part B. There is no 100-visit limit under Part B.

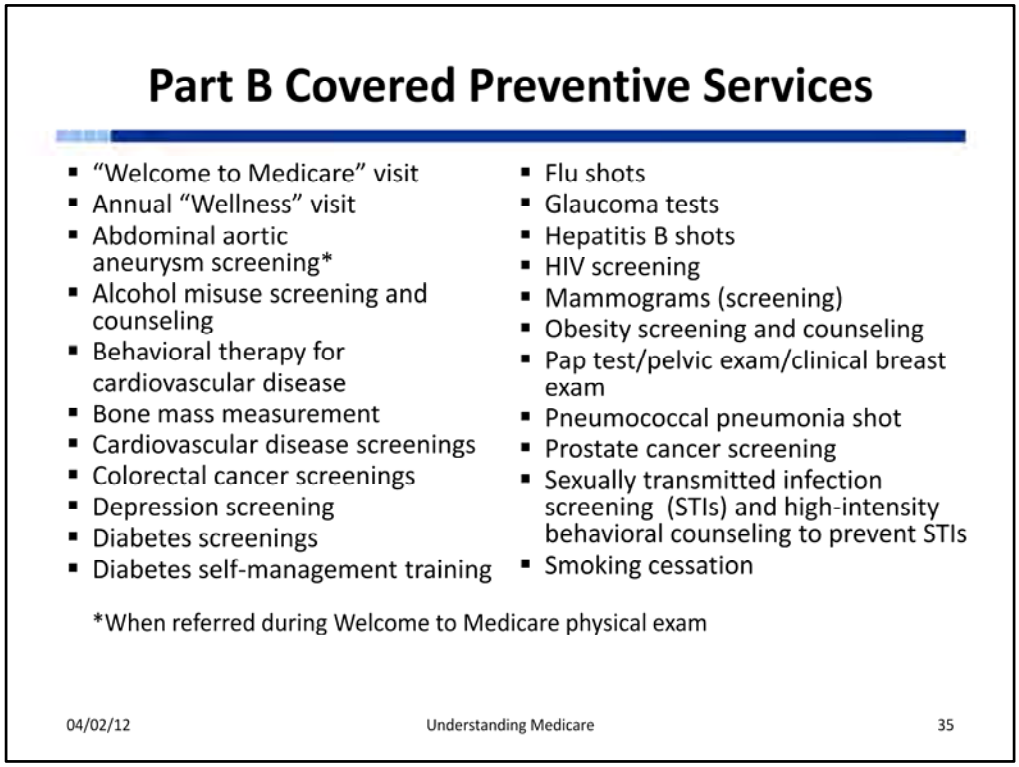


Durable Medical Equipment - Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare approved supplier for Medicare to pay. See Section 4312(b) of the Balanced Budget Act.

Medicare is phasing in a program called "competitive bidding" to help save you and Medicare money; ensure that you continue to get quality equipment, supplies, and services; and help limit fraud and abuse. In some areas of the country, if you need certain items, you must use specific suppliers, or Medicare won't pay for the item and you likely will pay full price. It's important to see if you're affected by this new program to ensure Medicare payment and avoid any disruption of service. This program is effective in parts of the following states: CA, FL, IN, KS, KY, MO, NC, OH, PA, SC, and TX. For more information on the competitive bidding program, visit our website at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html?redirect=/DMEPOSCompetitiveBid/

Other covered services include, but aren't limited to medically necessary clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary.

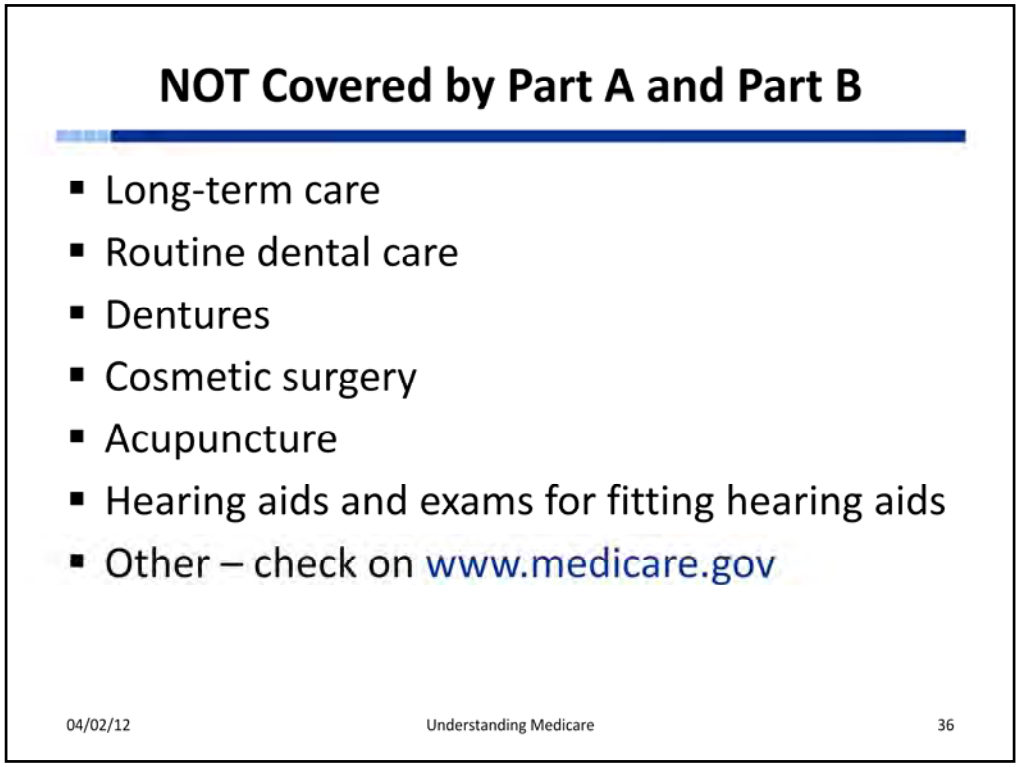
More information on Medicare coverage is available in the *Medicare & You* handbook, CMS Product No. 10050 or *Your Medicare Benefits*, CMS Product No. 10116 available online at www.medicare.gov.



Part B Covered Preventive Services include

- "Welcome to Medicare" visit
- Annual "Wellness" visit
- Abdominal aortic aneurysm screening*
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms (screening)
- Obesity screening and counseling
- Pap test/pelvic exam/clinical breast exam
- Pneumococcal pneumonia shot
- Prostate cancer screening
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

* When referred during Welcome to Medicare physical exam



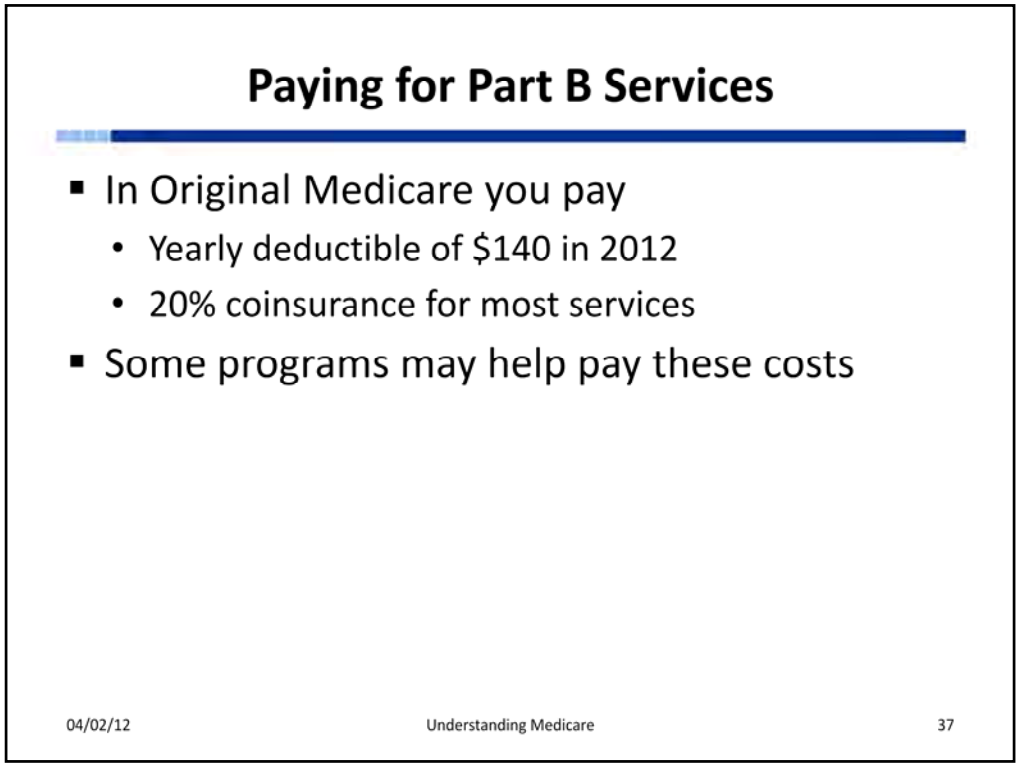
Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you will have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

Items and services that Medicare doesn't cover include, but aren't limited to, long-term care, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

Medicare Dictionary:

Long Term Care - Long-term care includes medical and non-medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need in the future.

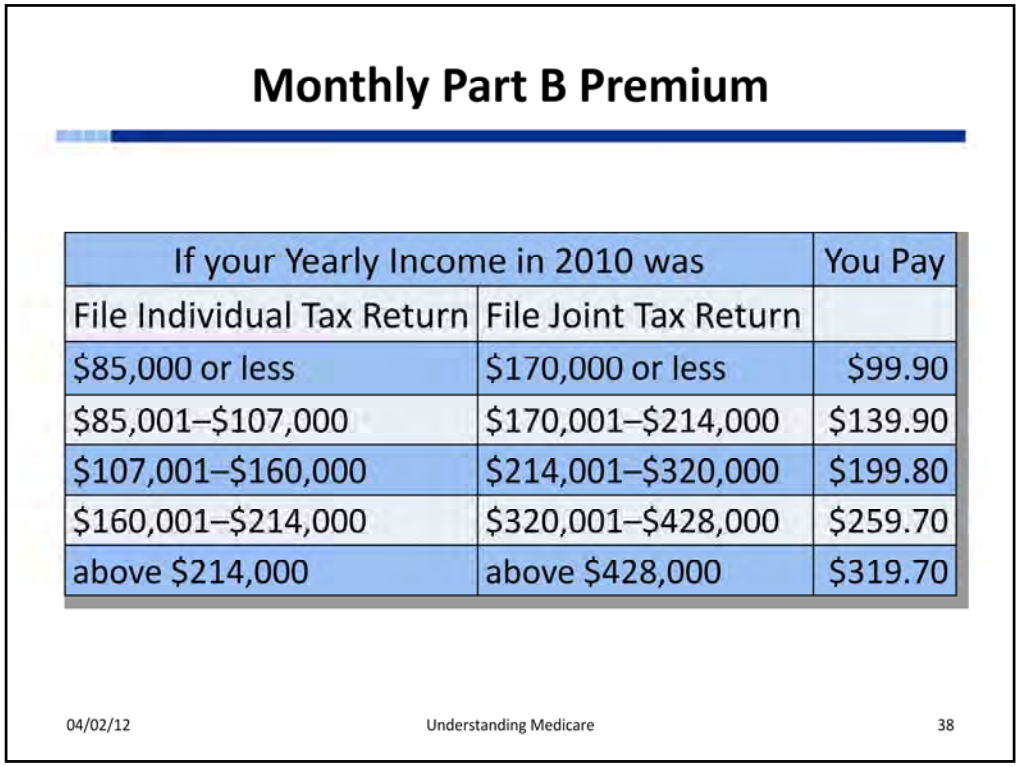
To find out if Medicare covers a service you need, visit www.medicare.gov and select "Find Out if Medicare Covers Your Test, Item, or Service," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. The 2012 Part B deductible is $140 per year. This means that you must pay the first $140 of your Medicare-approved medical bills in 2012 before Medicare Part B starts to pay for your care.

You also pay some copayments or coinsurance for Part B services. The amount depends upon the service, but is 20% in most cases.

If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation. See Lesson 4.



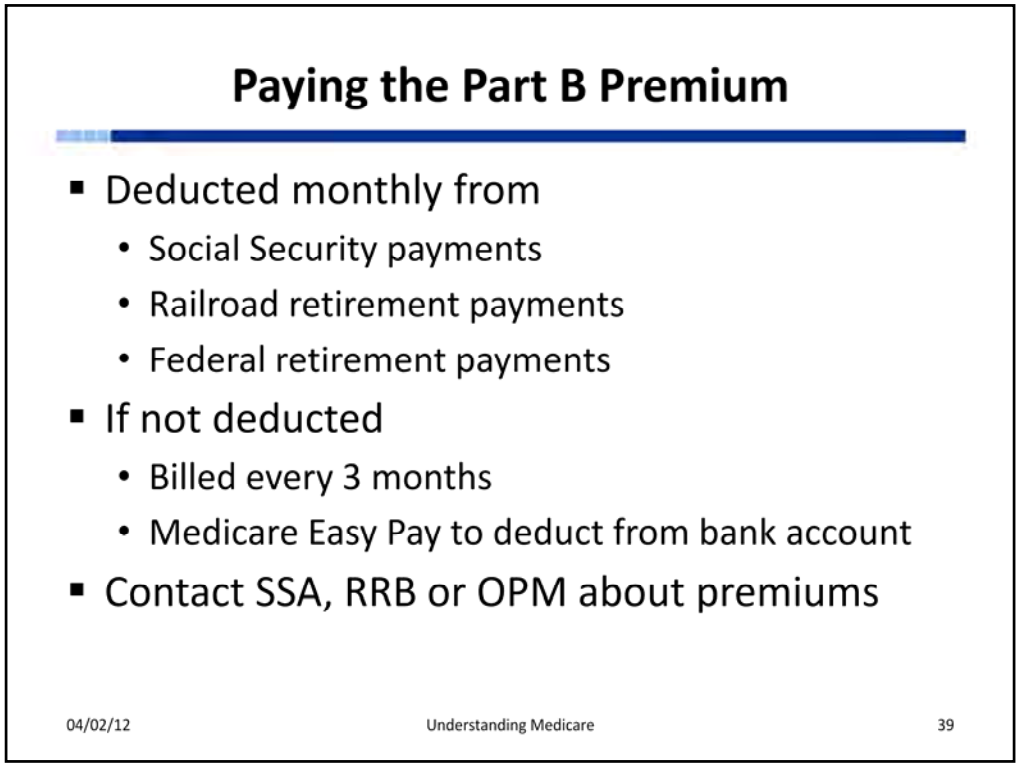
The standard Medicare Part B monthly premium is $99.90 in 2012, a $15.50 decrease over the 2011 premium of $115.40. However, most Medicare beneficiaries were held harmless in 2011 and paid $96.40 per month. The 2012 premium represents a $3.50 increase for them. Most beneficiaries will pay the 2012 premium of $99.90.

Some people with higher annual incomes pay a higher Part B premium. These amounts can change each year. See below for 2012 Part B premiums based on the modified adjusted gross income for an individual.

- $85,001 - $107,000, the Part B premium is $139.90 per month
- $107,001 - $160,000, the Part B premium is $199.80 per month
- $160,001 - $214,000 the Part B premium is $259.70 per month
- Greater than $214,000, the Part B premium is $319.70 per month

The income ranges for joint returns are double that of individual returns. Social Security uses the income reported on your tax return from two years ago to determine the Part B premium. For example, the income reported on a 2010 tax return filed in 2011 is used to determine the monthly Part B premium in 2012. Remember that this premium may be higher if you did not choose Part B when you first became eligible. The cost of Medicare Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. An exception would be if you or your spouse (or family member if you're disabled), is still employed and you are covered by a group health plan through that employment. In that case, you are eligible to enroll in Part B during a Special Enrollment Period. You will not pay a penalty. See slide 13.

Contact Social Security at 1-800-772-1213 if you filed an amended return or your income has gone down.

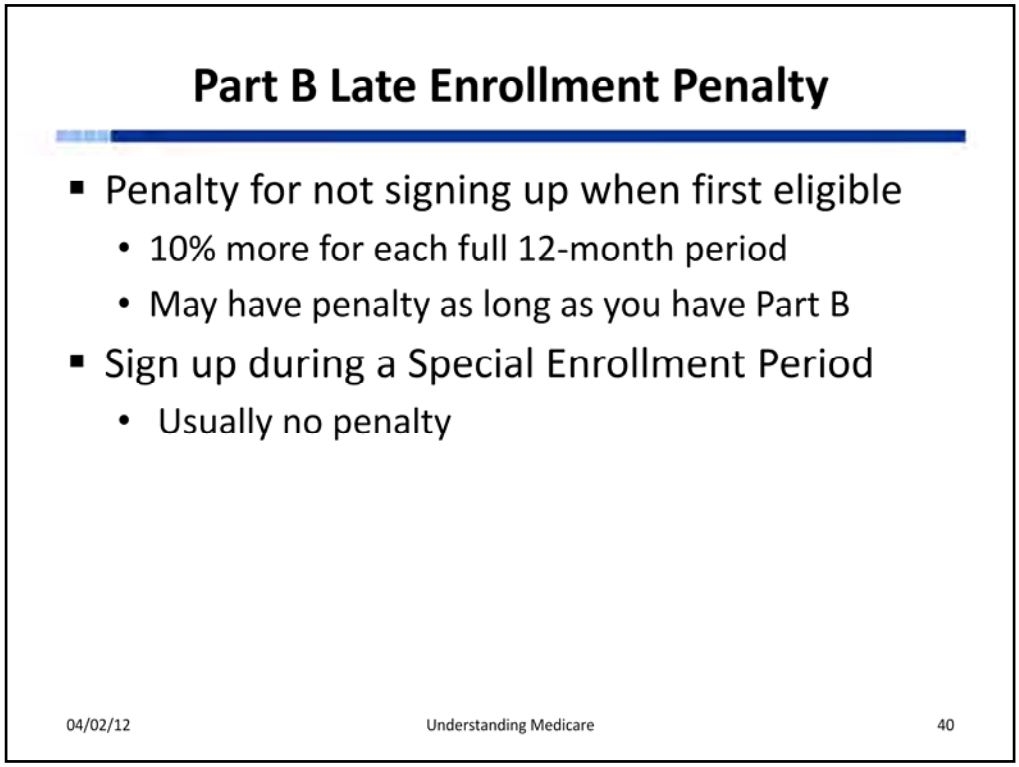


The Part B premium is deducted from monthly Social Security, Railroad Retirement or Federal retirement payments.

People who don't get a retirement payment or whose payment is not enough to cover the premium get a bill from Medicare for the Part B premiums. The bill can be paid by credit card, check, or money order.

For information about Medicare Part B premiums, call SSA, RRB, or the Office of Personnel Management (OPM) for retired Federal employees.

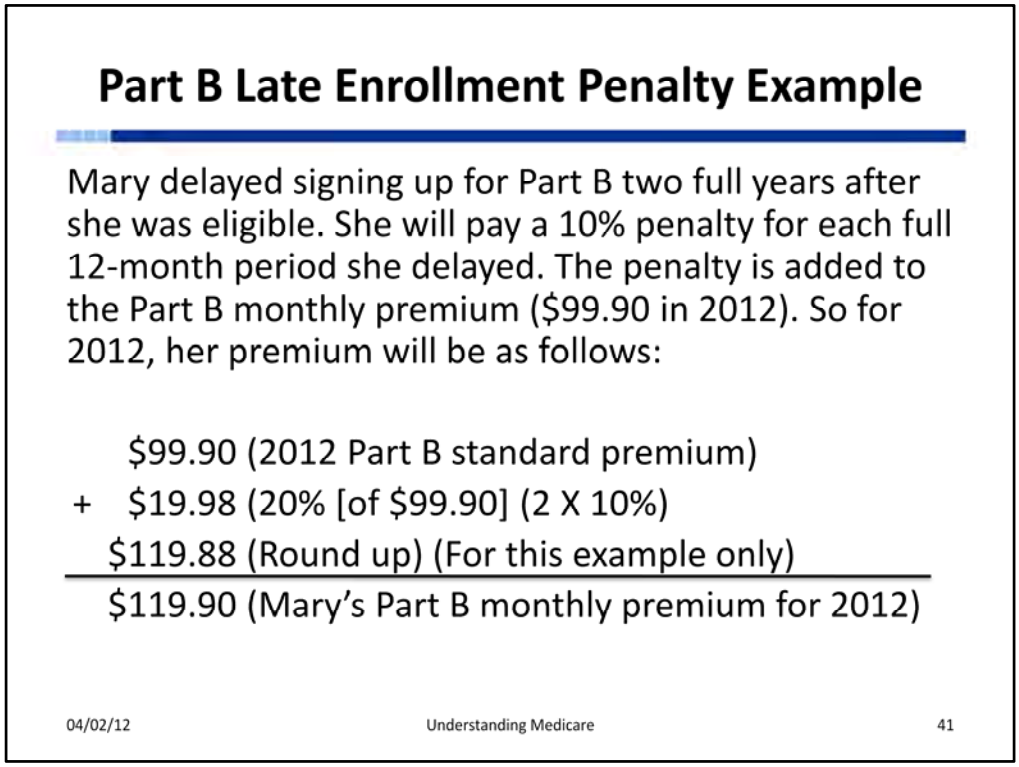
If you can't afford to pay the Part B premium, there are programs that may help you. See Lesson 4.



If you don't sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare.

Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it.

Usually, you don't pay a late enrollment penalty if you sign up for Part B during a Special Enrollment Period (SEP). See slide 13.

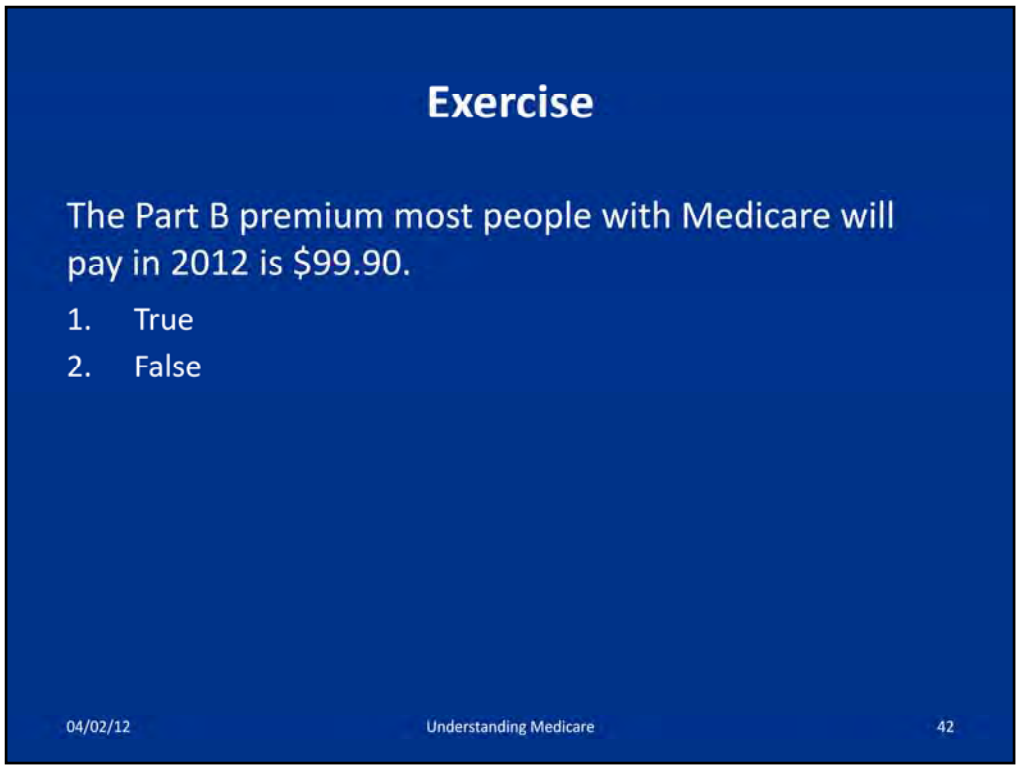


This is an example of how someone might compute a late enrollment penalty for Part B.

Mary delayed signing up for Part B two full years after she was eligible. She will pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($99.90 in 2012). So for 2012, her premium will be as follows:

$99.90 (2012 Part B standard premium)
+$19.98 (20% [of $99.90] (2 X 10%)
$119.88 (Round up) (For this example only)

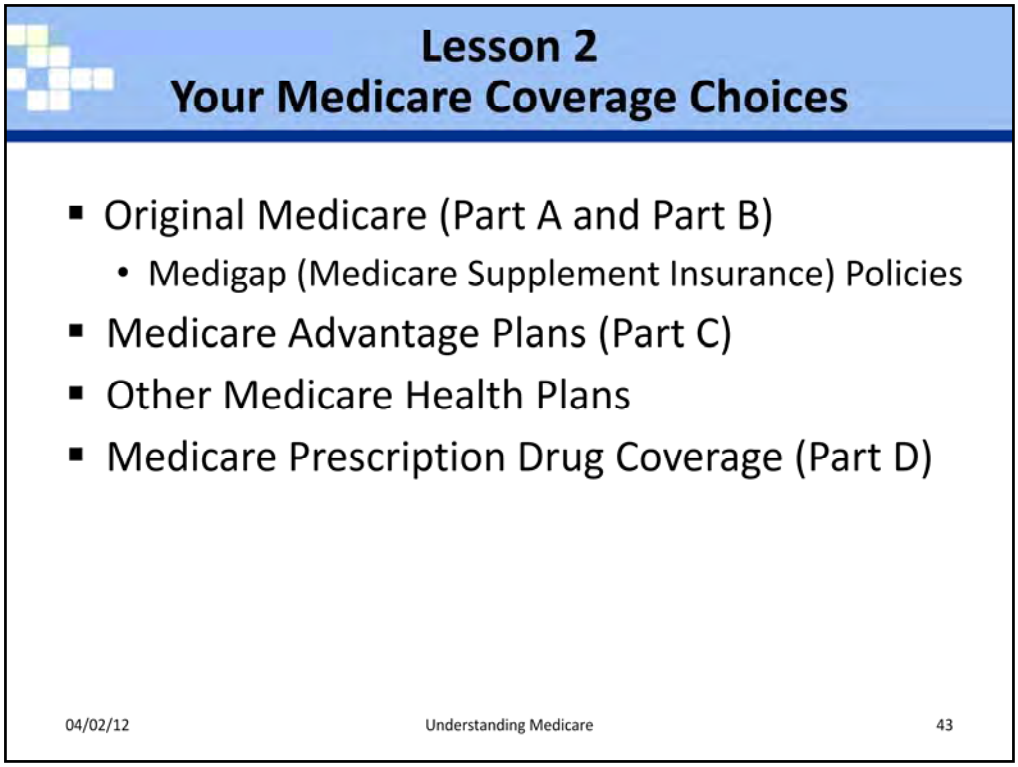
$119.90 (Mary's Part B monthly premium for 2012)



Exercise
The Part B premium most people with Medicare will pay in 2012 is $99.90.

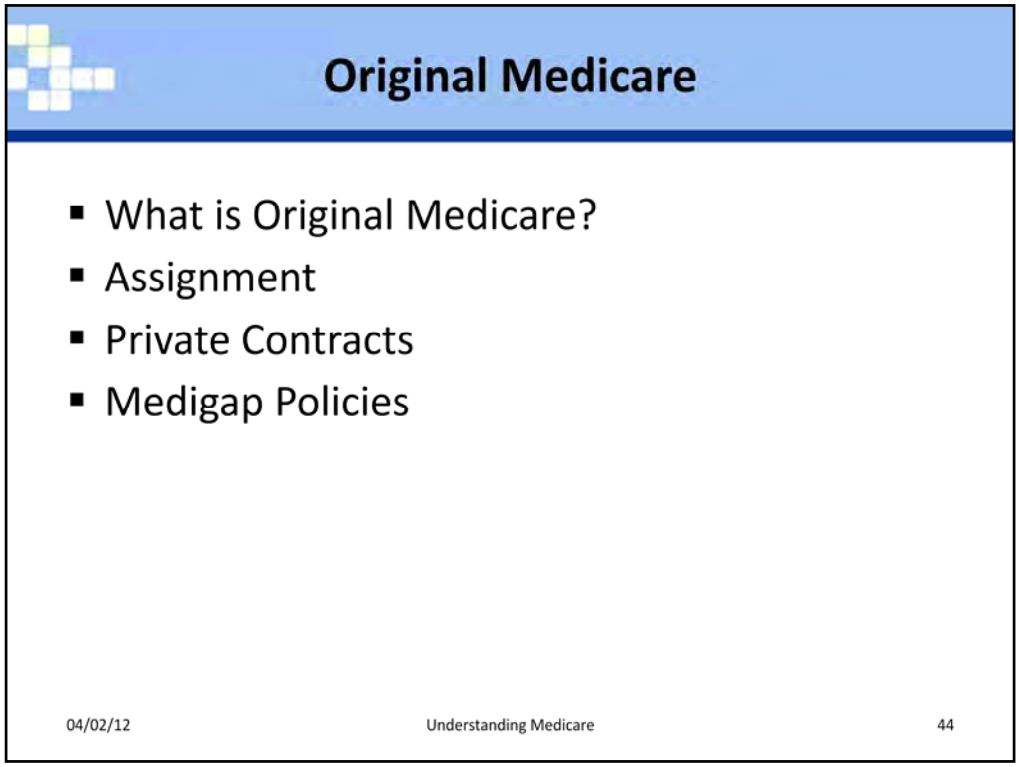
1. True
2. False

Answer: 1. True
The standard Medicare Part B monthly premium is $99.90 in 2012, a $15.50 decrease over the 2011 premium of $115.40. However, most Medicare beneficiaries were held harmless in 2011 and paid $96.40 per month. The 2012 premium represents a $3.50 increase for them. Most beneficiaries will pay the 2012 premium of $99.90.



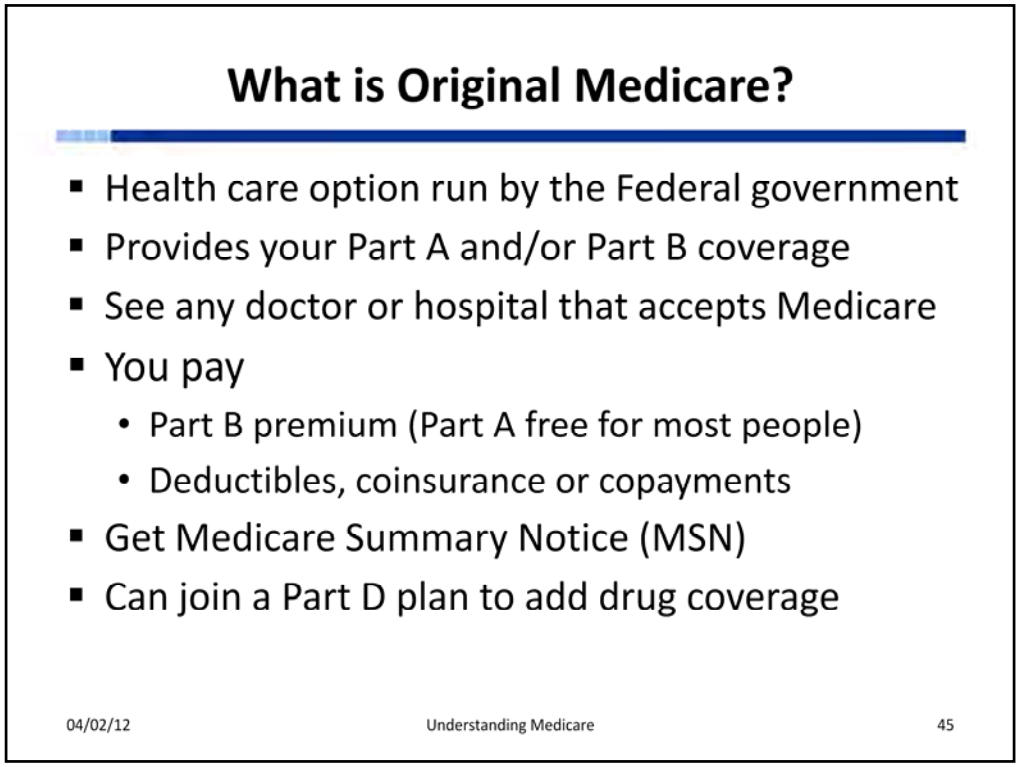
In Lesson 2 we will discuss Medicare coverage choices:

- Original Medicare (Part A and Part B)
  - Medigap (Medicare Supplement Insurance) Policies
- Medicare Advantage (Part C) and Other Medicare Plans
- Medicare Prescription Drug Coverage (Part D)



Original Medicare explains the following:

- What is Original Medicare?
- Assignment
- Private Contracts
- Medigap Policies



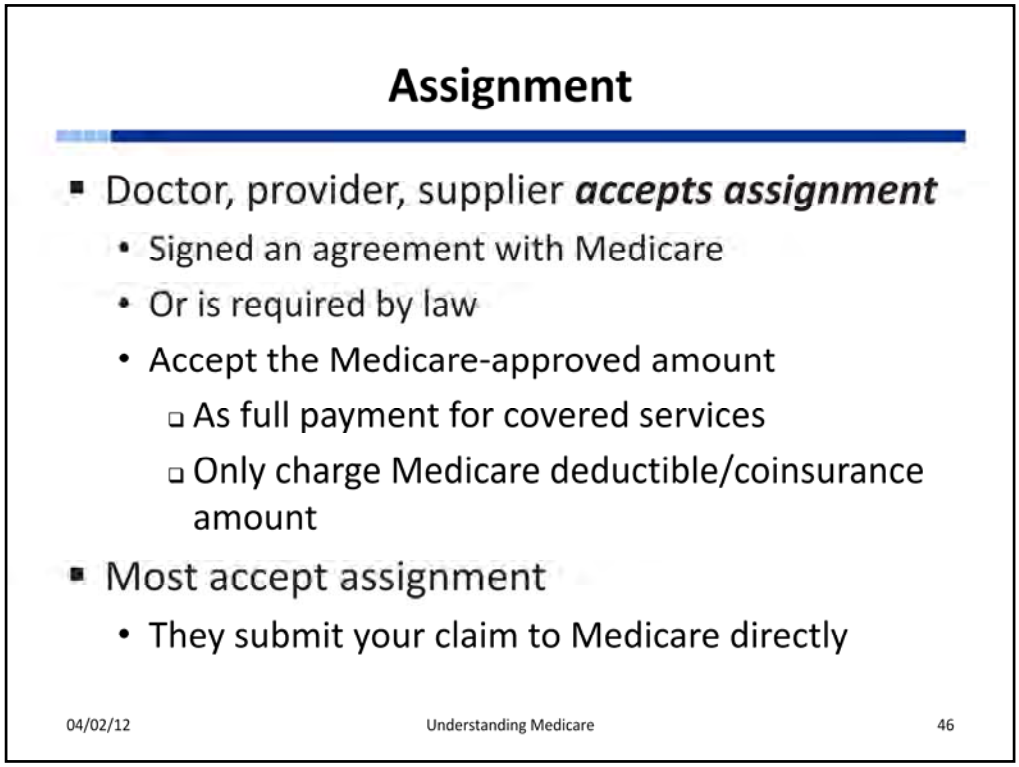
Original Medicare is one of the coverage choices in the Medicare program. You will be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare plan. Original Medicare is a fee-for-service program that is managed by the Federal Government.

If you have Medicare Part A, you get all the Part A-covered services. If you have Medicare Part B, you get all the Part B-covered services. As we mentioned earlier, Part A (hospital insurance) is premium-free for most people. For Medicare Part B (medical insurance) you pay a monthly premium. The standard Medicare Part B monthly premium is $99.90 in 2012.

With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

In Original Medicare, you also pay deductibles and coinsurance or copayments. After you receive health care services, you'll get a notice in the mail, called a Medicare Summary Notice (MSN), that lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There is information on the MSN about how to ask for an appeal.

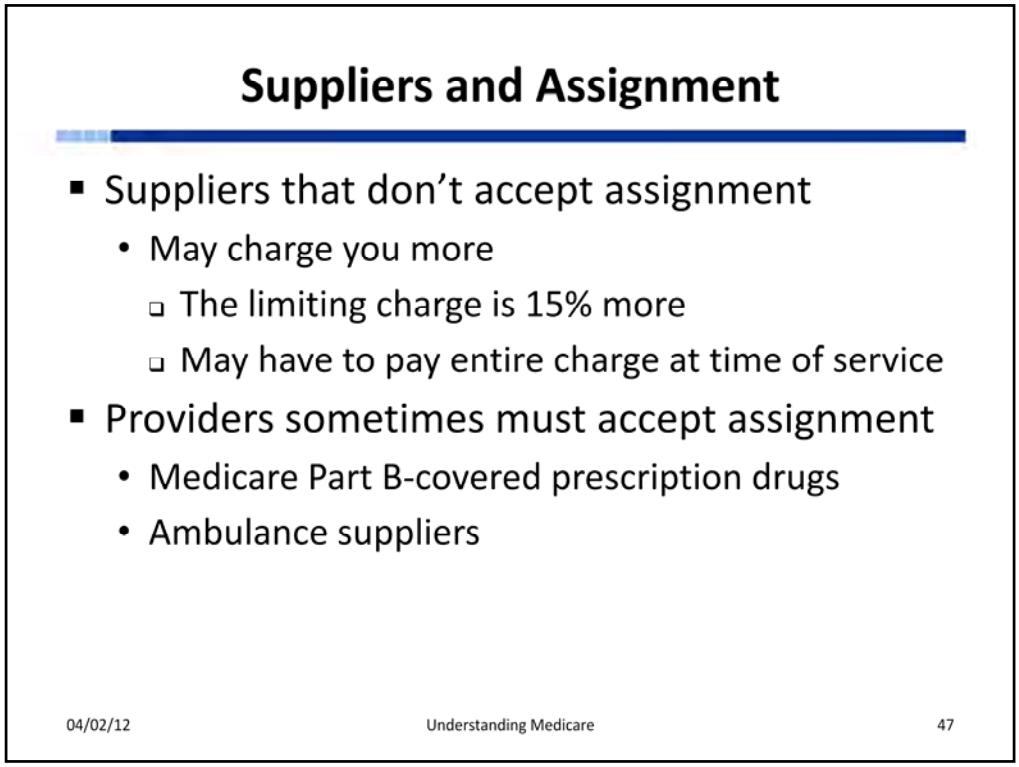
If you are in Original Medicare, you can join a Medicare Prescription Drug Plan (Part D plan) to add drug coverage.



Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure, because some who are enrolled in Medicare don't accept assignment.

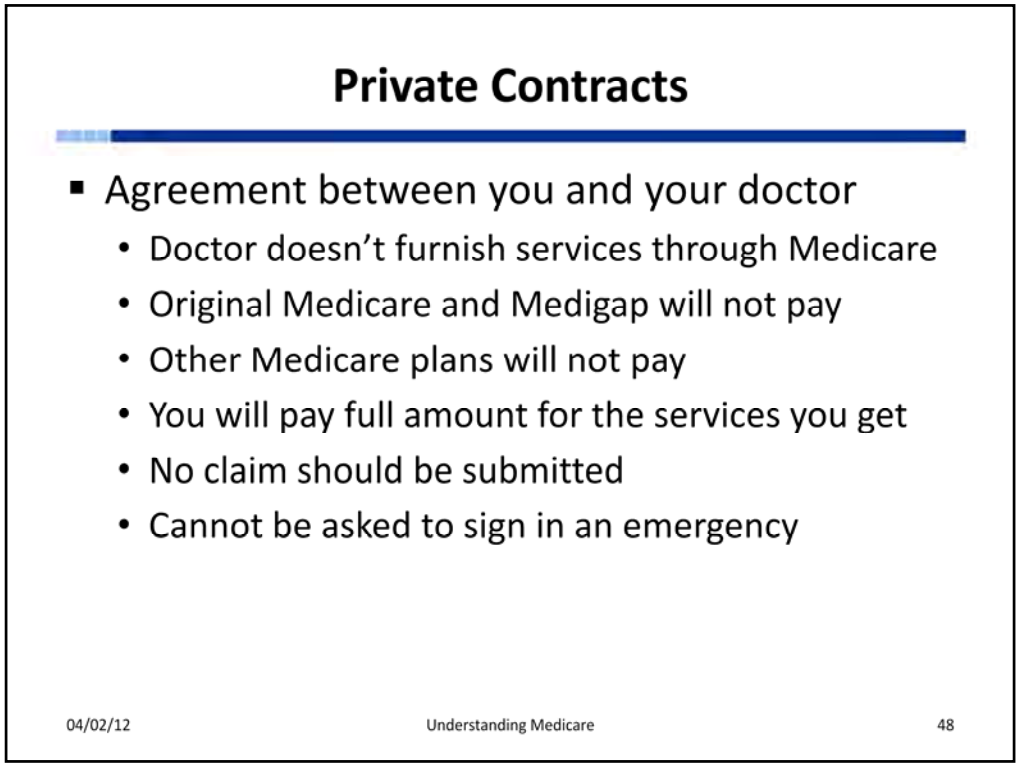
In some cases, doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services.



If your doctor, provider, or supplier doesn't accept assignment

- You might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back using form CMS-1490S. Visit www.medicare.gov/medicareonlineforms for the form and instructions, or call 1-800-MEDICARE.
- They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you up to 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

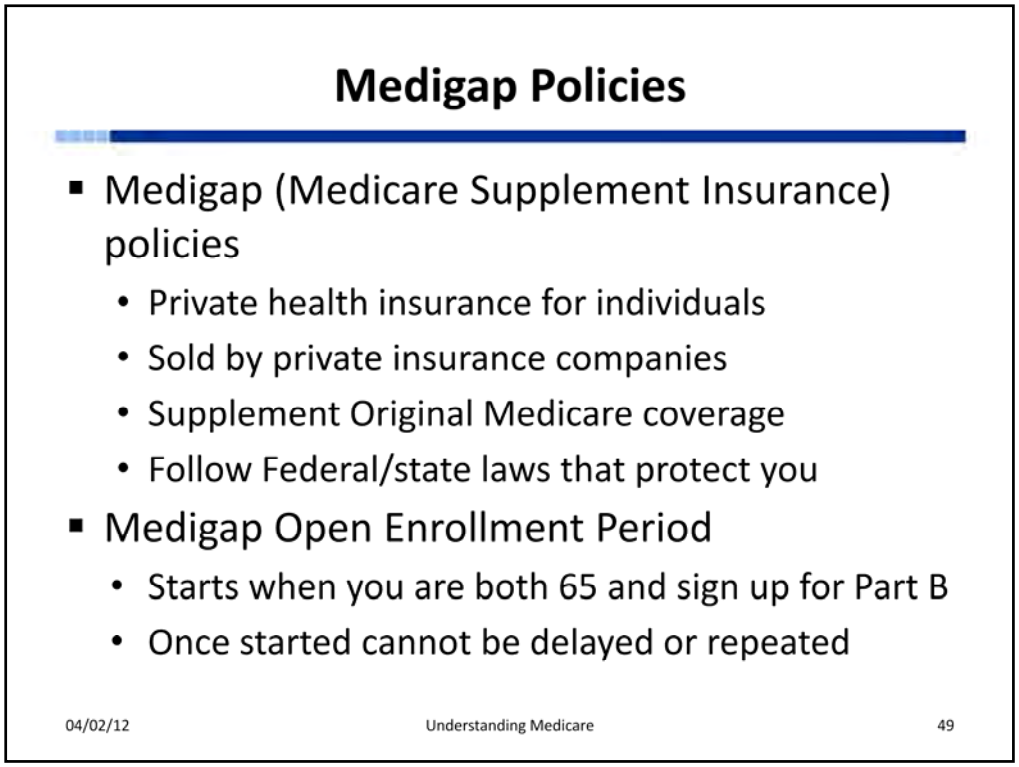
Caution: If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, they are supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
- You will have to pay whatever this doctor or provider charges you. (The Medicare limiting charge will not apply.)
- Other Medicare plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Many other insurance plans will not pay for the service either.
- The doctor cannot bill Medicare for 2 years for any services provided to anyone with Medicare.

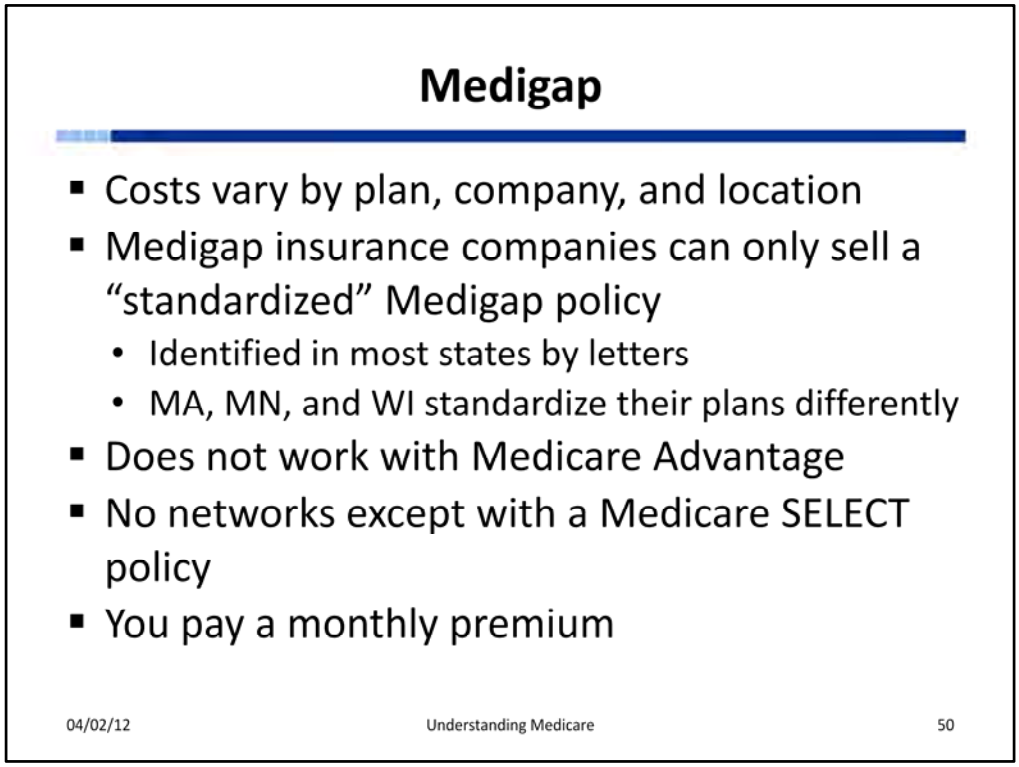


Medigap (Medicare Supplement Insurance) policies

- Are private health insurance that cover only the policy holder, not the spouse
- Are sold by private insurance companies
- Supplement Original Medicare (help pay for "gaps" in Original Medicare coverage - like deductibles, coinsurance, and copayments)
- Pay for Medicare-covered services provided by any doctor, hospital, or provider that accepts Medicare (the exception is Medigap SELECT policies that require you use specific hospitals, and in some cases, specific doctors to get full benefits).
- May cover certain things Medicare doesn't depending on the Medigap plan
- Must follow Federal and state laws that protect people with Medicare

Medigap Open Enrollment Period

- Starts when you are both 65 and sign up for Part B
- Once started cannot be delayed or repeated



With a Medigap policy, costs can vary by plan, company, and location. Medigap insurance companies can only sell "standardized" Medigap policies that are Identified in most states by letters.

Massachusetts, Minnesota, and Wisconsin are waiver states and standardize their plans differently.

Medigap policies do not work with Medicare Advantage plans.

Medigap policies have no networks except with a Medicare SELECT policy.

You pay a monthly premium for a Medigap policy to the insurance company that sells it.

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		

Basic benefits are covered by all Medigap plans. They include

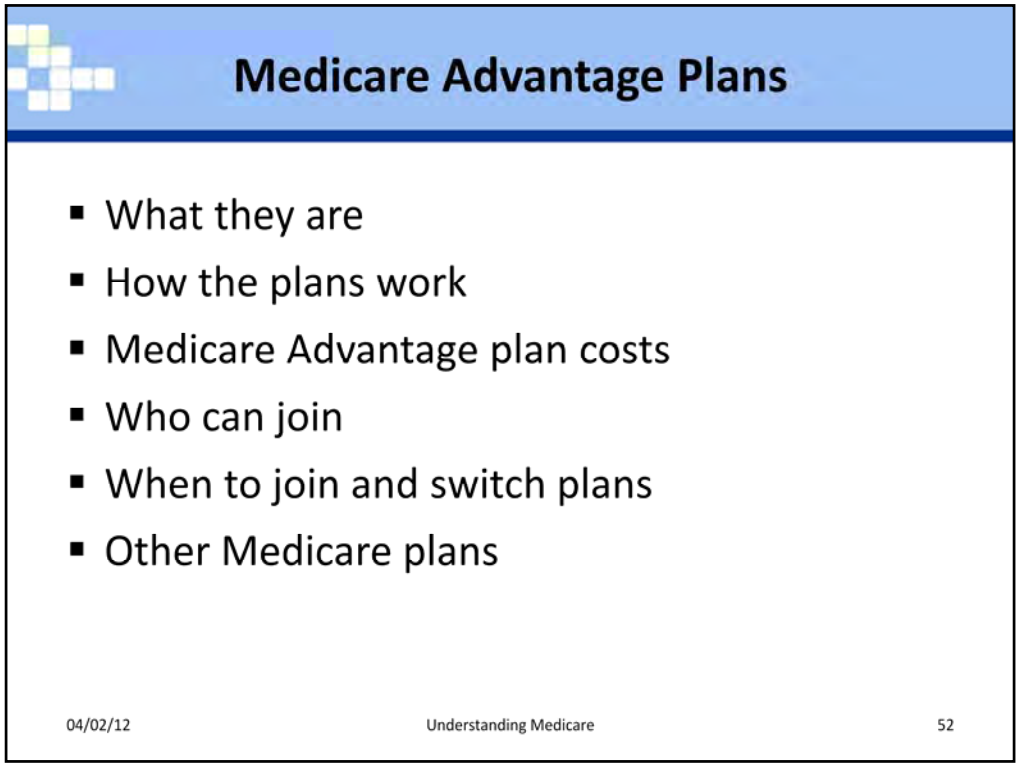
- Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up
- Medicare Part B coinsurance or copayment
- Blood (First 3 Pints)
- Part A Hospice care coinsurance or copayment

NOTE: Plan N pays 100% of the Part B coinsurance, except for a copay of up to $20 for some office visits and up to $50 for emergency room visits that don't result in an inpatient admission.

Each Medigap plan covers different additional benefits.

- Skilled Nursing Facility care coinsurance - Medigap Plans C, D, F, G, K (at 50%), L (at 75%), M, and N
- Medicare Part A deductible - Medigap Plans B, C, D, F, G, K (at 50%), L (at 75%), M (at 50%) and N
- Medicare Part B deductible - Medigap Plans C and F
- Medicare Part B excess charges (the amount a health care provider is legally permitted to charge that is higher than the Medicare-approved amount) - Medigap Plans F and G
- Foreign Travel Emergency costs up to the Plan's limits - Medigap Plans C, D, F, G, M and N

NOTE: A full size version of this chart is in the corresponding workbook. See Appendix A.

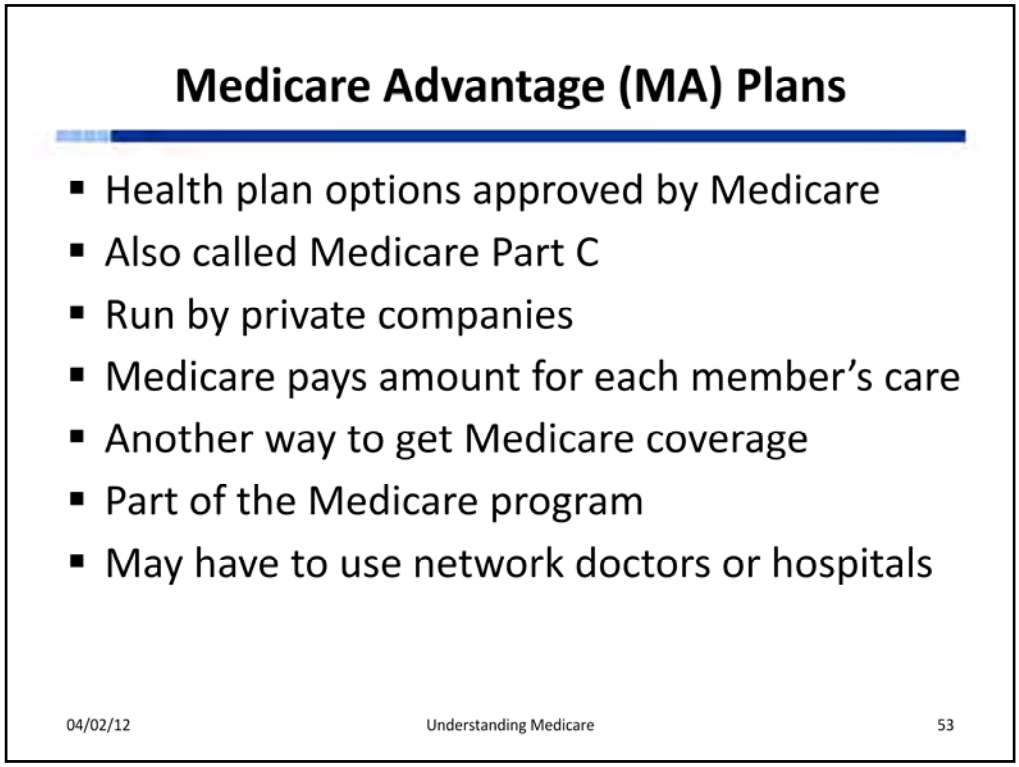


Medicare Advantage Plans

- What they are
- How the plans work
- Medicare Advantage Plan costs
- Who can join
- When to join and switch plans
- Other Medicare plans

See Module 11 for more information on Medicare Advantage Plans.

NOTE: In this lesson, when we use the term "Medicare Advantage Plans," we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not include Original Medicare or stand-alone Medicare Prescription Drug Plans.)



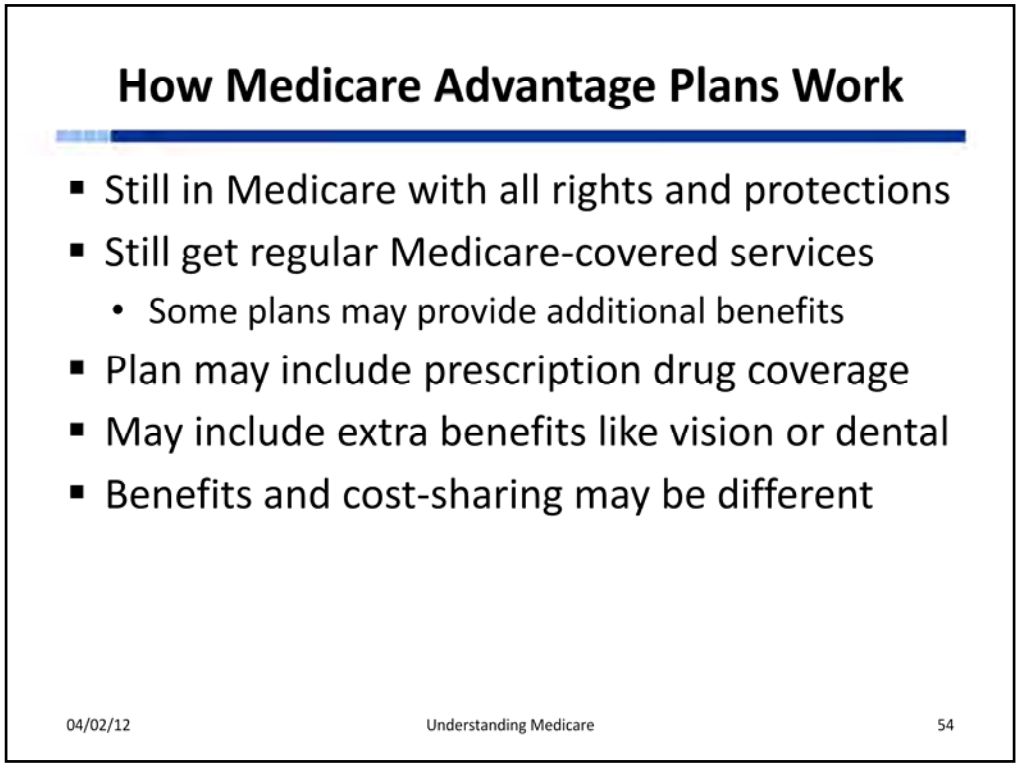
Medicare Advantage Plans are health plan options that are approved by Medicare. Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare.

They are part of the Medicare program, and are sometimes called Medicare Part C.

Medicare pays a set amount of money to these private health plans for their members' health care.

You are still in the Medicare program.

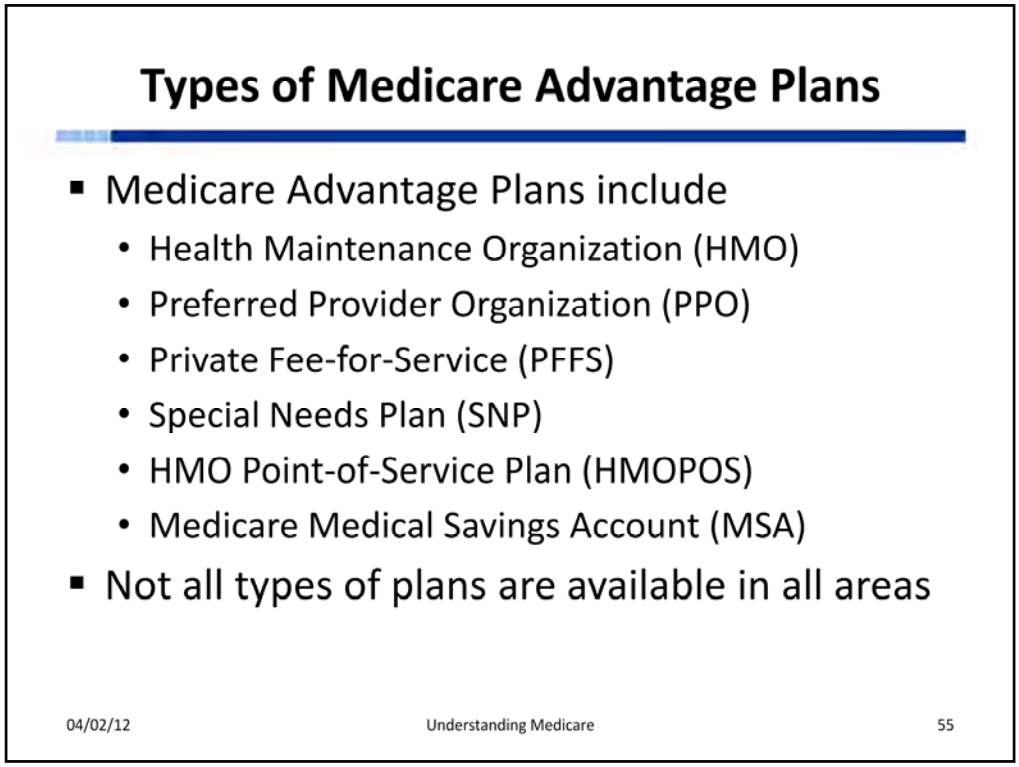
In a Medicare Advantage Plan, you may have to use doctors and hospitals that belong to the plan.



If you join a Medicare Advantage Plan, you still have Medicare rights and protections. You still get all your regular Medicare-covered services offered under Part A and Part B.

You may get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care, and/or health and wellness programs.

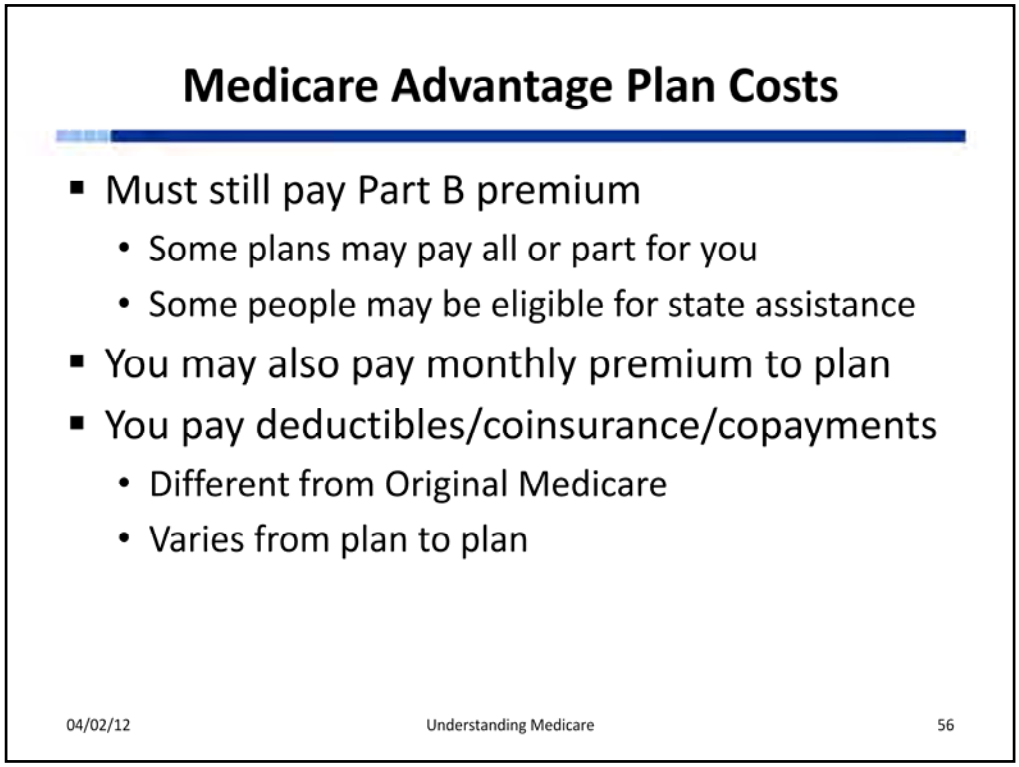
Benefits and cost-sharing may be different than in Original Medicare.



There are six main types of Medicare Advantage Plans:

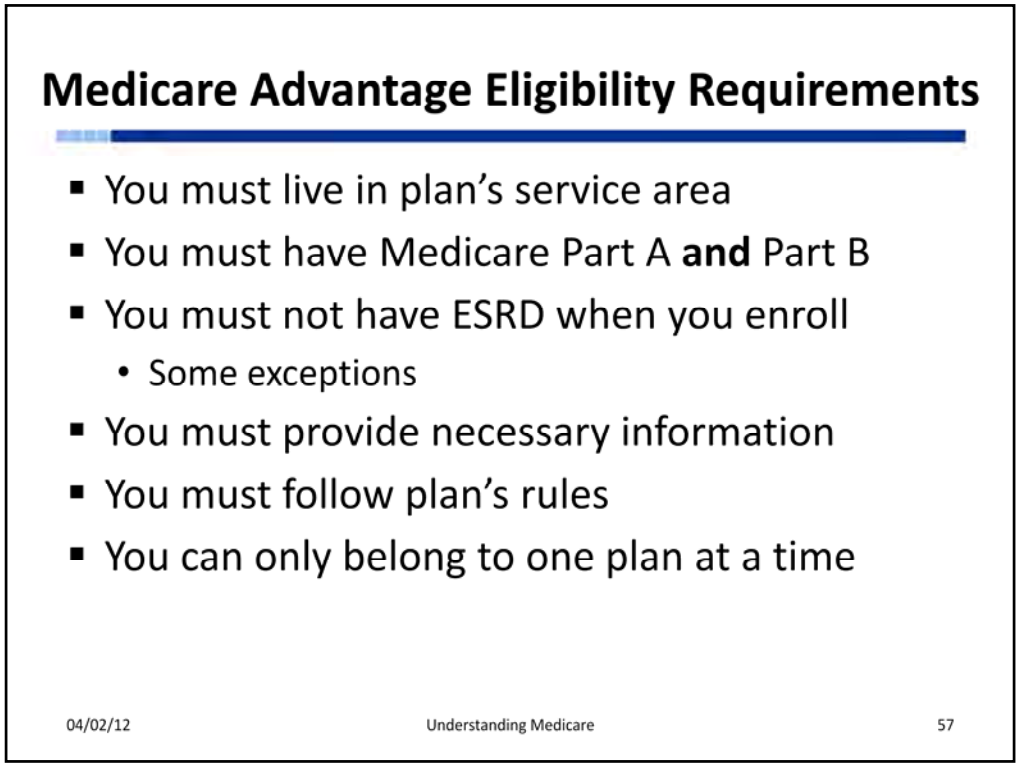
- **Medicare Health Maintenance Organization (HMO) Plans**—managed care plans that cover all Part A and B services and may provide extra services. You can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.
- **Medicare Preferred Provider Organization (PPO) Plans**—similar to an HMO plan, but members can see any doctor or provider that accepts Medicare, and they don't need a referral to see a specialist. Going to a provider that isn't part of the plan's network will usually cost more.
- **Medicare Private Fee-for-Service (PFFS) Plans**—members can go to any provider that accepts the plan's terms, and may get extra benefits. The private company decides its share and member's share for services.
- **Medicare Special Needs Plans (SNP)**—membership is limited to certain groups of people, such as those in certain institutions (like a nursing home), those eligible for both Medicare and Medicaid, or those with certain chronic or disabling conditions.
- **HMO Point-of-Service (HMOPOS) Plans**—an HMO plan that may let you get some services out of network for a higher cost.
- **Medicare Medical Savings Account (MSA) Plans**—two part plans similar to Health Savings Account plans available outside of Medicare. These MA plans have high deductibles that must be met before plan begins to pay covered costs. Deductibles vary by plan. The second part of this type plan is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

Not all types of plans are available in all areas.



If you join a Medicare Advantage (MA) Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2012 is $99.90. Some plans may pay all or part of the Part B premium for you. Some people may be eligible for state assistance to help pay some of their costs.

If you join an MA plan, you may pay have to pay an additional monthly premium to plan. You also pay deductibles, coinsurance and copayments that are different from Original Medicare. The costs vary from plan to plan.



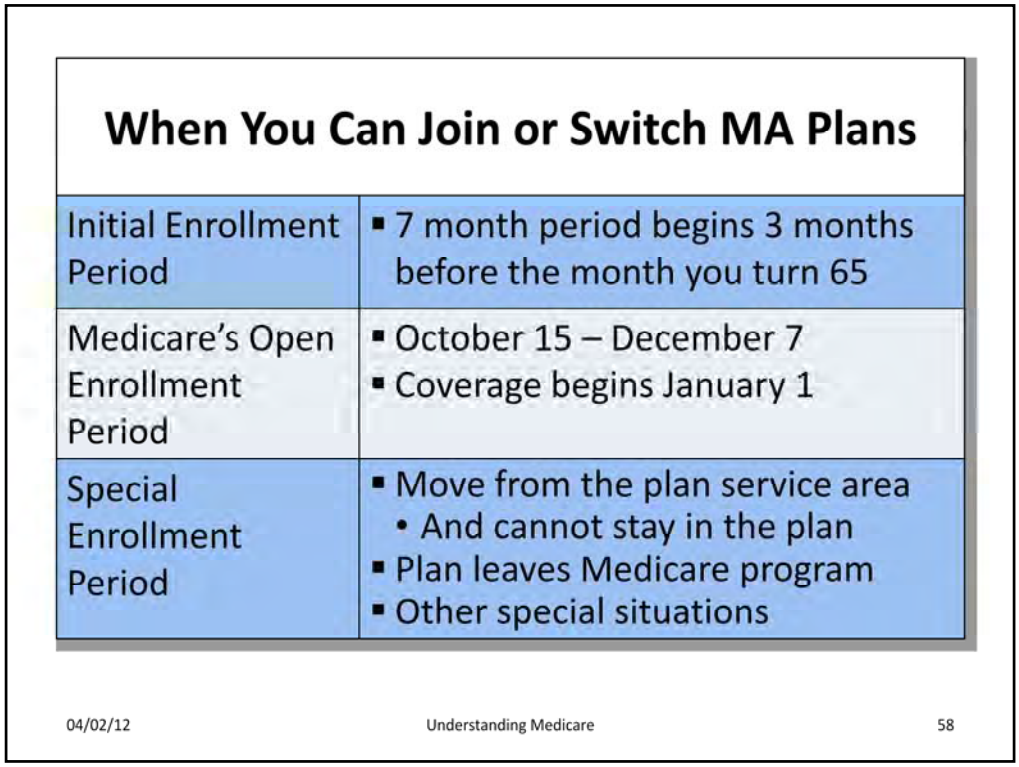
Medicare Advantage Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, you must

- Live in the plan's geographic service area or continuation area
- Have Medicare Part A **and** Part B
- Not have End-Stage Renal Disease (ESRD) when you enroll. People with ESRD usually can't join a Medicare Advantage Plan or other Medicare plan. However, there are some exceptions.

In addition, you must

- Agree to provide the necessary information to the plan
- Agree to follow the plan's rules
- Belong to only one plan at a time

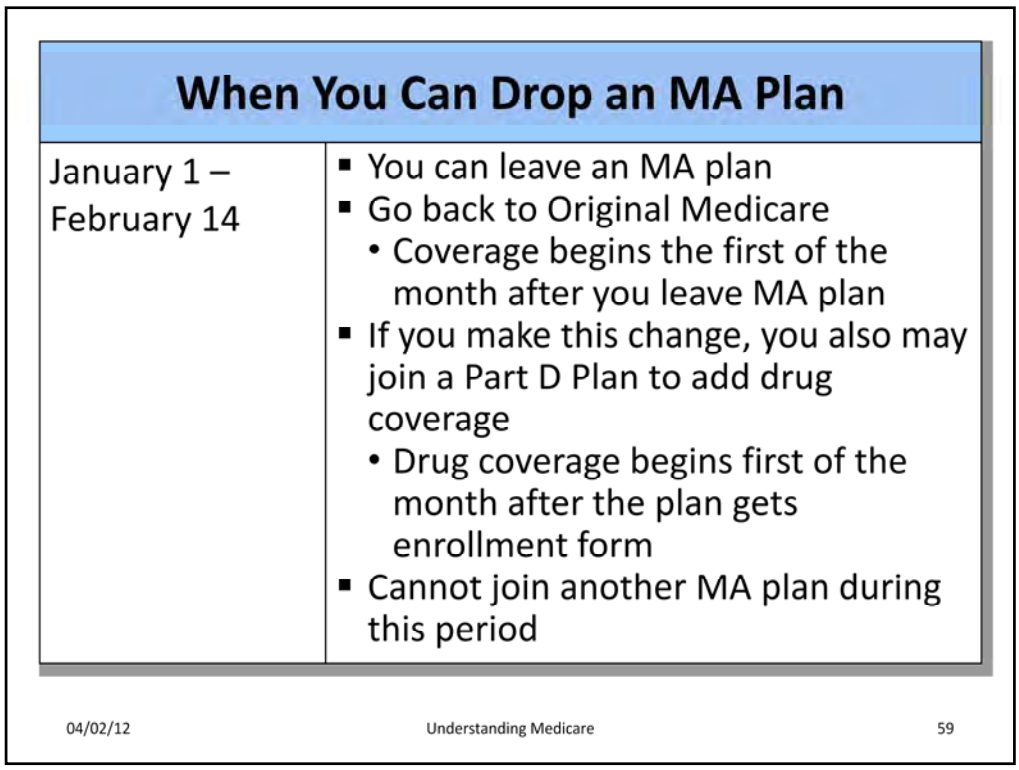
To find out what Medicare Advantage Plans are available in your area, visit www.medicare.gov and choose the link Compare Drug and Health Plans to use the Medicare Plan Finder, or call 1-800-MEDICARE (1-800-633-4227).



You can join a Medicare Advantage Plan when you first become eligible for Medicare, during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B. You can also join or switch plans during Medicare's Open Enrollment Period (also known as Open Enrollment), which runs from October 15 – December 7 (coverage begins January 1 if you make your change during the AEP). In certain special situations you may get a Special Enrollment Period. This would be in situations such as your plan leaving Medicare, or you move out of the service area of the plan.

You can only join one Medicare Advantage Plan at a time, and enrollment in a plan is generally for a calendar year.

See Section 3204 of the Affordable Care Act.

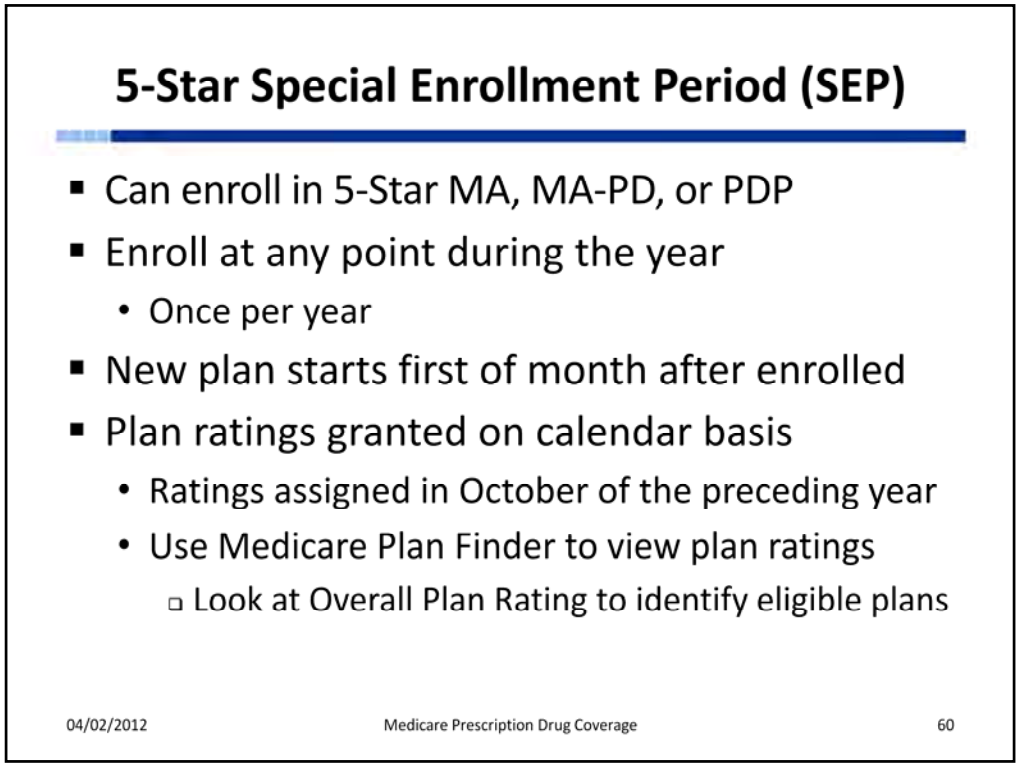


If you belong to a Medicare Advantage (MA) Plan, you can switch to Original Medicare from January 1 – February 14. If you go back to Original Medicare during this time, coverage under Original Medicare will take effect on the first day of the calendar month following the date on which the election or change was made.

To disenroll from an MA plan and return to Original Medicare during this period, you can

- Make a request directly to the MA plan
- Call 1-800-MEDICARE
- If you make this change you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

See Section 3204 of the Affordable Care Act.



You can use this SEP to enroll in a 5-star Medicare Advantage-only plan, a 5-star Medicare Advantage plan with prescription drug coverage, or a 5-star Medicare Prescription Drug Plan at any time during the year, provided you meet the plan's enrollment requirements (e.g., living within the service area, etc.). If you are currently enrolled in a plan with a 5-star overall rating, you may use this SEP to switch to a different plan with a 5-star overall rating.

CMS also created a coordinating SEP for prescription drug plans to allow people who enroll in certain types of 5-star plans without drug coverage to select a prescription drug plan, if this combination is permitted under CMS rules.

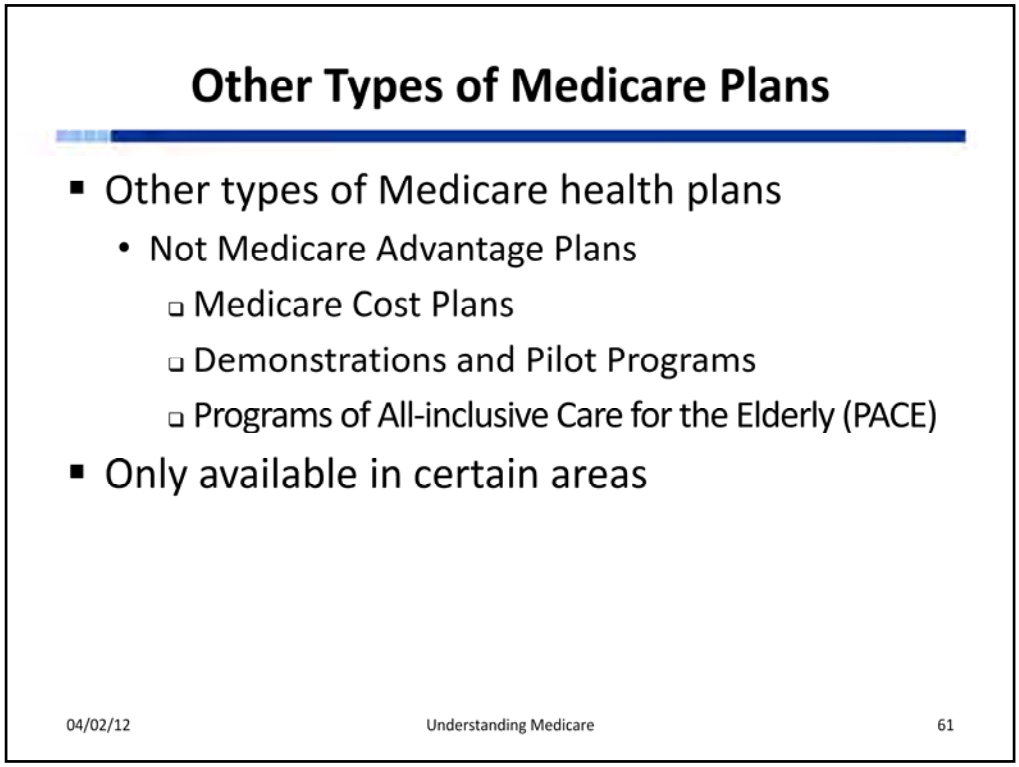
You may use the 5-star SEP one time between December 8 and November 30 of the following year. Once you enroll in a 5-star plan, your SEP ends for that plan year and you are limited to making changes only during other applicable enrollment periods.

Your enrollment effective date will be the first day of the month following the month in which the plan receives your enrollment request.

Star ratings are granted on a calendar year basis, and are assigned in October of the preceding year. The plan won't actually have the rating until January 1, but will be assigned the rating in the October prior to that January 1.

To find plan rating information, visit the Medicare Plan Finder at www.medicare.gov. Look for the Overall Plan Rating to identify plans that are eligible for use with this SEP.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You will have to wait until the next applicable enrollment period to get drug coverage and you may have to pay a late enrollment penalty.



There are three other types of other Medicare health plans that are not Medicare Advantage Plans. These plan types are available only in limited areas.

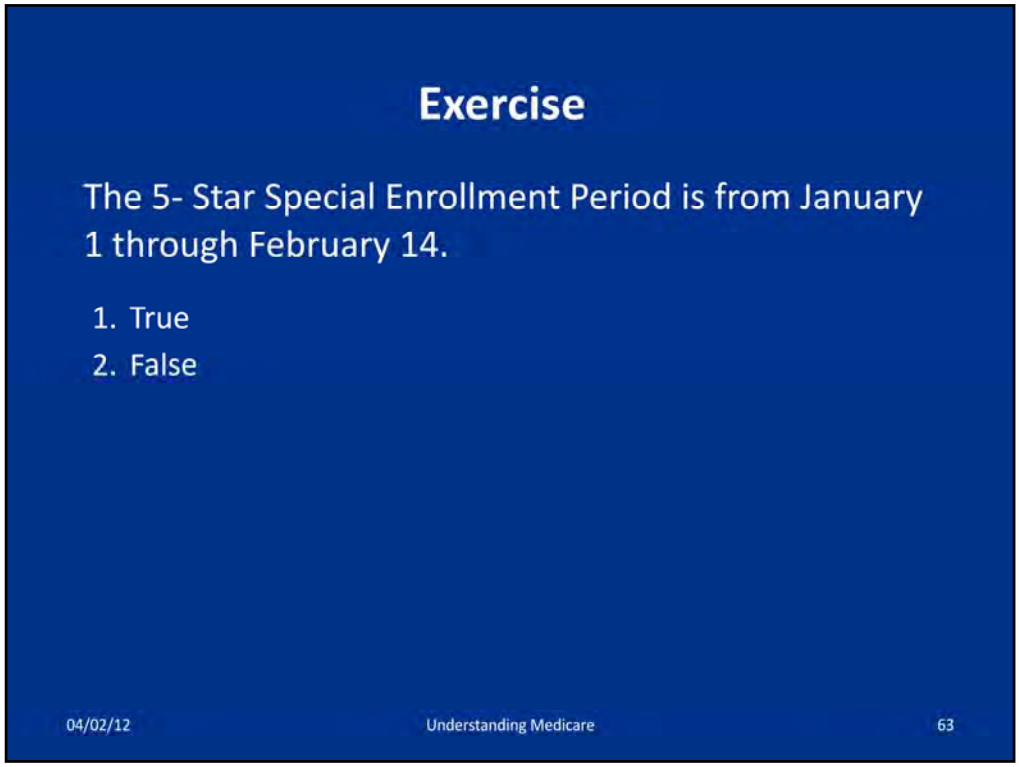
- **Medicare Cost Plans**—similar to a Health Maintenance Organization (HMO), but services received outside the plan are covered under Original Medicare.
- **Demonstrations and pilot programs**—special projects that test possible future improvements in Medicare coverage, costs, and quality of care.
- **PACE (Programs of All-inclusive Care for the Elderly)**—combines medical, social, and long-term care services for frail elderly people who are eligible for both Medicare and Medicaid.

Exercise

Cost Plans are a type of Medicare Advantage Plan.

1. True
2. False

Answer: 2. False
Cost plans are not Medicare Advantage Plans.



Exercise

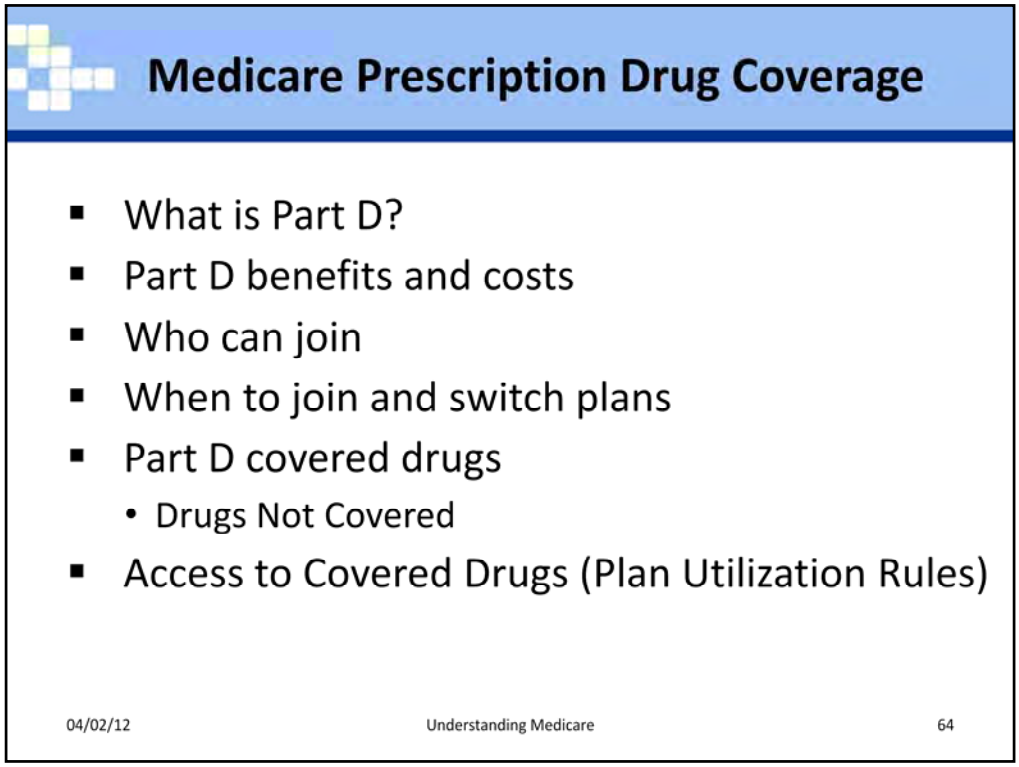
The 5-Star Special Enrollment Period is from January 1 through February 14.

1. True
2. False

Answer: 1. False

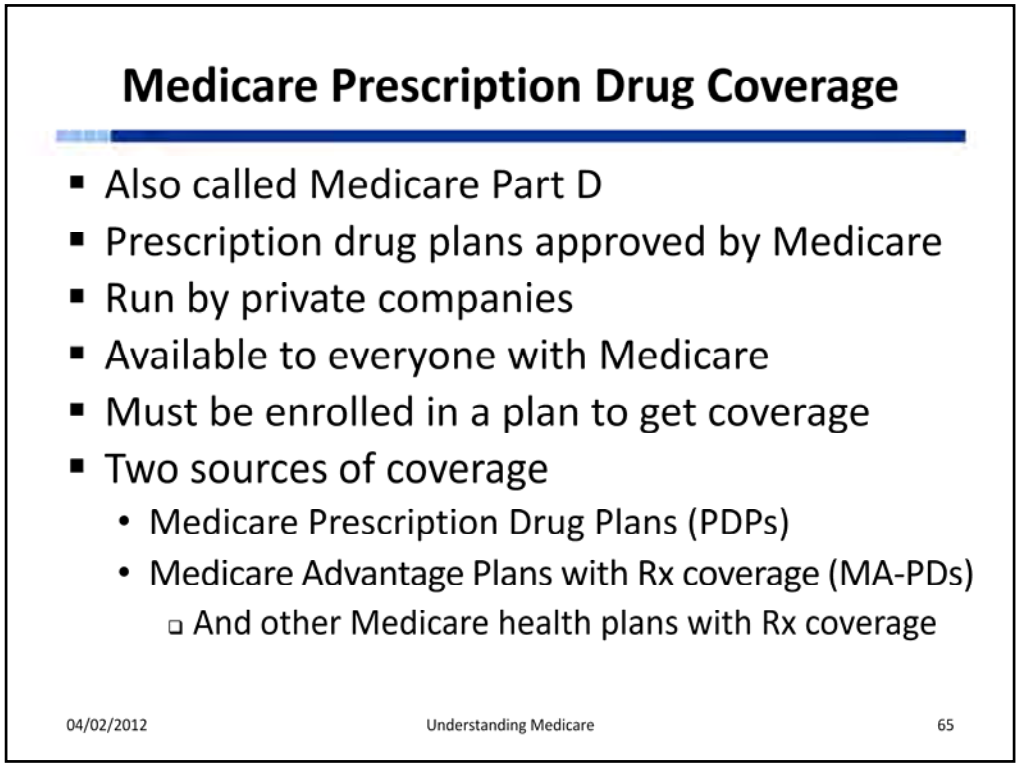
You may use the 5-star SEP one time between December 8 and November 30 of the following year. Once you enroll in a 5-star plan, your SEP ends for that plan year and you are limited to making changes only during other applicable enrollment periods.

From January 1 – February 14 each year, you can only disenroll from a Medicare Advantage Plan and move to Original Medicare. You can't switch to a different Medicare Advantage Plan. You can join a Medicare Prescription Drug Plan to add Part D drug coverage when you switch to Original Medicare.



Medicare Prescription Drug Coverage explains the following:

- What is Part D?
- Part D benefits and costs
- Who can join
- When to join and switch plans
- Part D Covered Drugs
  - Drugs Not Covered
- Access to Covered Drugs (Plan Utilization Rules)



Medicare Prescription Drug Plans are approved by Medicare and run by private companies.

All people with Medicare are eligible to enroll in a Medicare prescription drug plan.

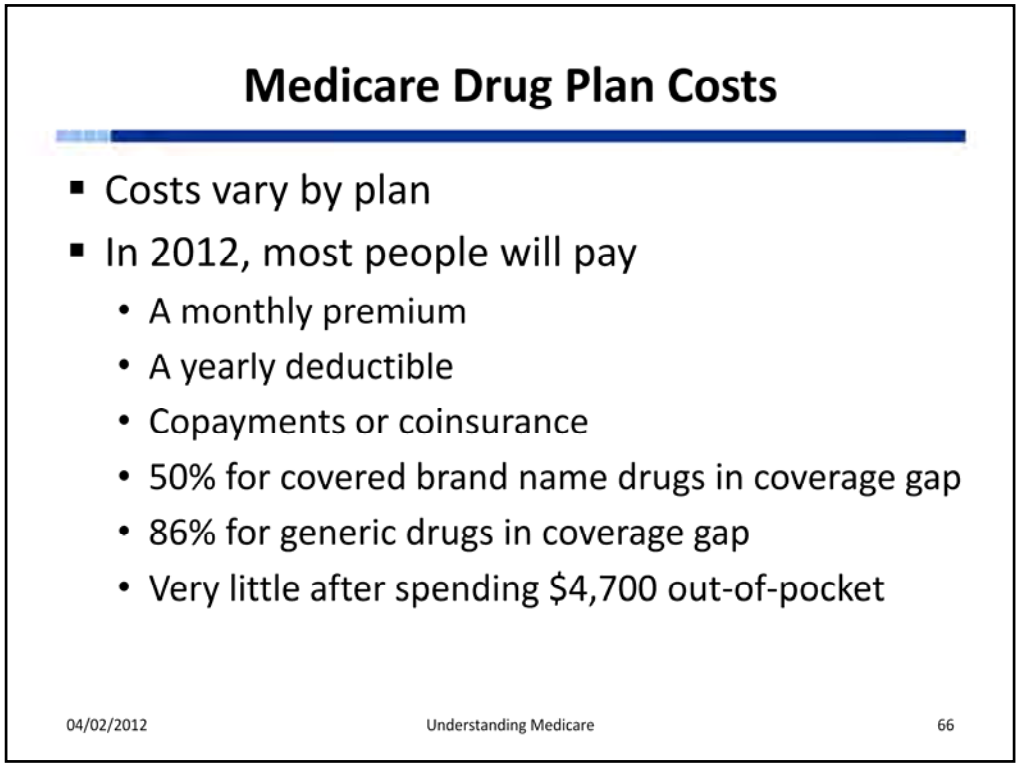
You must be enrolled in a plan to get Medicare prescription drug coverage.

There are two types of Medicare drug plans:

- Medicare Prescription Drug Plans add coverage to Original Medicare and some other types of Medicare plans.
- Some Medicare Advantage Plans (like an HMO or PPO) and other Medicare plans also offer Medicare prescription drug coverage.

The term "Medicare drug plan" is used throughout this presentation to mean both Medicare Prescription Drug Plans and Medicare Advantage or other Medicare plans with prescription drug coverage.

NOTE: Some Medicare Supplement Insurance (Medigap policies) offered prescription drug coverage prior to January 1, 2006. This is not Medicare prescription drug coverage.



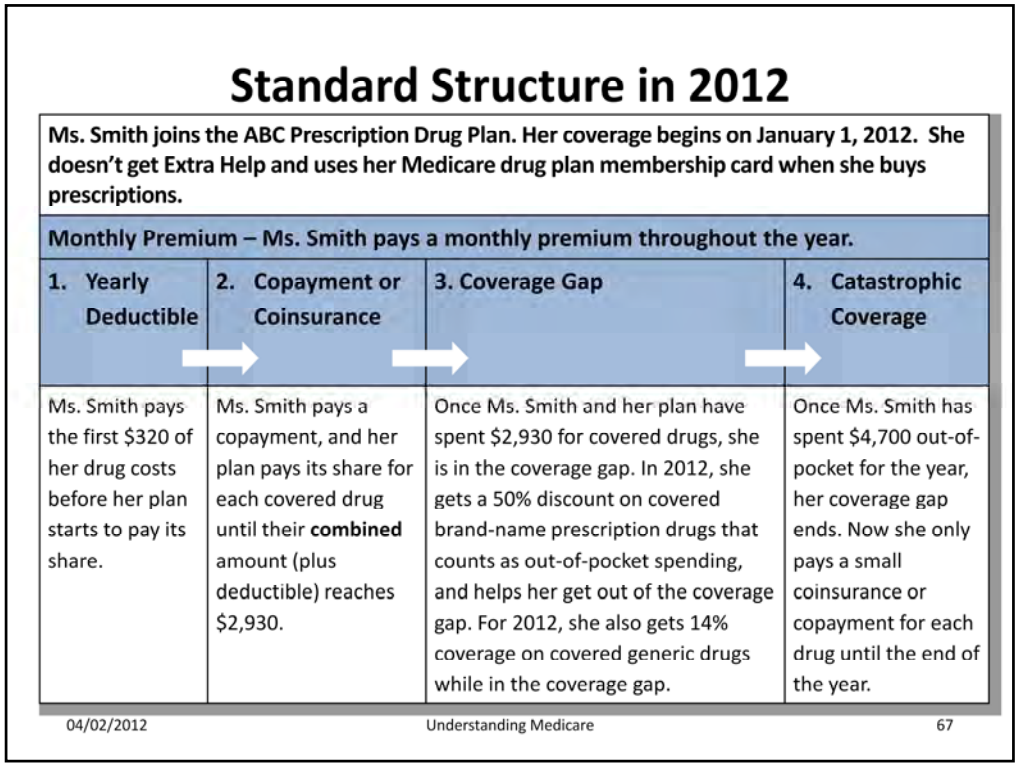
Your prescription drug costs will vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, set by Medicare. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium.

In 2012, you will get a 50% discount on brand name drugs and a 14% discount on generic drugs while in the coverage gap. In 2013, you will get a 52.5% discount on brand name drugs and a 21% discount on generic drugs while in the coverage gap. By 2020, you will get a 75% discount both for covered generic and brand-name drugs while in the gap.

With every plan, once you have paid $4,700 out of pocket (this includes payments from other sources, including the 50% discount paid for by the plan in the coverage gap) for drugs costs in 2012, you will pay 5% (or a small copayment) for each drug for the rest of the year.

People with limited income and resources may be able to get Extra Help paying for their Medicare drug plan costs.

NOTE: Please see Appendix B for more information about the standard Medicare Part D cost and benefit structure.



This is an example showing what you would pay each year in a defined standard Medicare drug plan. Very few plans actually follow this design. Your drug plan costs will vary.

Monthly premium—Varies by plan. You still pay the Part B premium if you have Part B. In a Medicare Health Plan (like an HMO or PPO) with drug coverage, the plan premium may include prescription drug coverage.

Yearly deductible (you pay $320 in 2012)—What you pay for prescriptions before your plan begins to pay. Some drug plans don't have a deductible.

Copayments or coinsurance (you pay 25%)—Your share at the pharmacy for your covered prescriptions after the deductible. The drug plan pays its share.

Coverage gap (you pay 100%)—Most plans have a coverage gap, which begins after you and your drug plan have spent a certain amount of money for covered drugs ($2,930 in 2012). In 2012, you will continue to get a 50% discount on brand-name drugs that counts toward your out-of-pocket spending, and helps you get out of the coverage gap.

Catastrophic coverage (you pay 5%)—Once you reach your plan's out-of-pocket limit, you get "catastrophic coverage" and you only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

NOTE: Please see Appendix B for more information about the standard Medicare Part D cost and benefit structure.

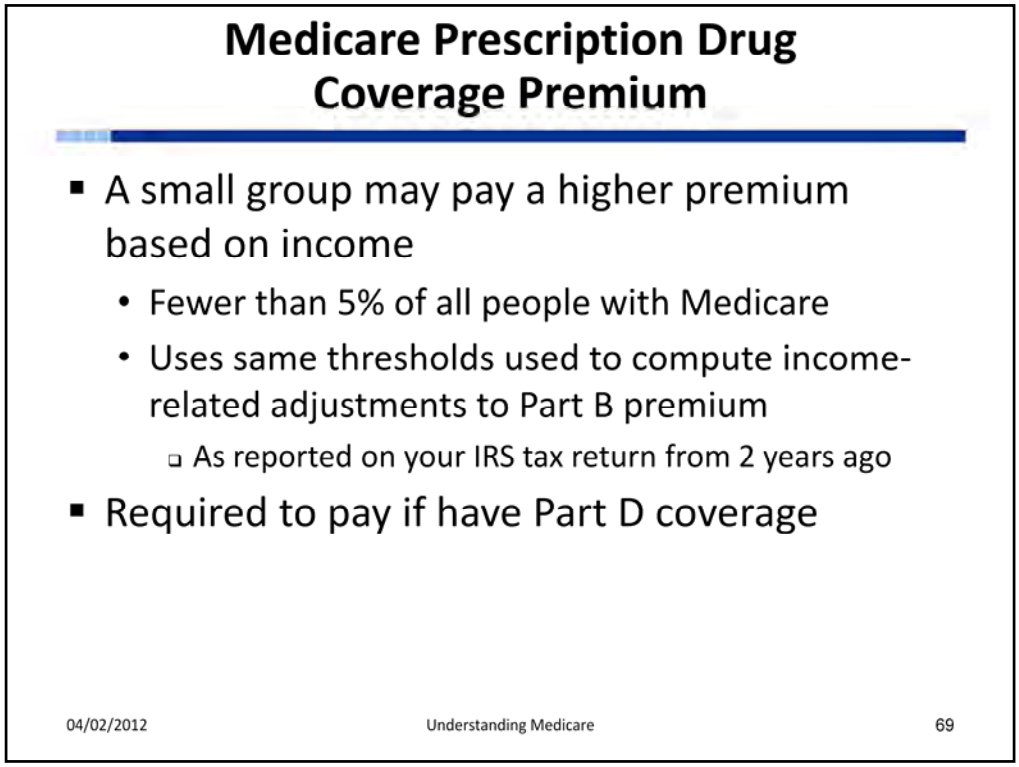
Reference: Page 14 of *Your Guide to Medicare Prescription Drug Coverage* (CMS Product No. 11109).

Improved Coverage in the Coverage Gap

Year	What You Pay for Brand Name Drugs in the Coverage Gap	What You Pay for Generic Drugs in the Coverage Gap
2012	50%	86%
2013	47.5%	79%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Note: Dispensing fees are not discounted.

In addition to the 50% discount on covered brand-name prescription drugs, there will be increasing savings for you in the coverage gap each year until 2020.



A small group—affecting fewer than 5% of all people with Medicare—may pay a higher monthly premium based on their income. If your income is above a certain limit, you will pay an extra amount in addition to your plan premium. The Social Security Administration (SSA) uses income data from the Internal Revenue Service (IRS) to determine whether or not you have to pay a higher premium. The income limits are the same as those for the Part B income-related monthly premium adjustment amount (IRMAA).

Usually, the extra amount will be deducted from your Social Security check. If you don't have enough money in your Social Security check, you will be billed for the extra amount each month by either CMS or the Railroad Retirement Board (RRB). This means that you will pay your plan each month for your monthly premium and pay CMS or RRB each month for your IRMAA amount. (The Part D IRMAA amount is paid directly to the government and not the plan.) This also applies if you have Part D coverage through your employer (but not through retiree drug subsidy or other creditable coverage).

If you have to pay an extra amount and you disagree (for example, if you have a life event that lowers your income), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. For more information, visit www.socialsecurity.gov.

Reference: Social Security Administration, SSA Publication No. 05-10536 December 2011

See Section 3308 of the Affordable Care Act.

Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2010 was		In 2012 You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
$85,000.01 – $107,000	$170,000.01 – $214,000	YPP + $11.60*
$107,000.01 – $160,000	$214,000.01 – $320,000	YPP + $29.90*
$160,000.01 – $214,000	$320,000.01 – $428,000	YPP + $48.10*
Above $214,000	Above $428,000	YPP + $66.40*
*per month		

You pay only your plan premium if your yearly income in 2010 was $85,000 or less for an individual or $170,000 or less for a couple.

You pay your plan premium plus an extra amount, based on your yearly income, if your yearly income in 2010 was higher than $85,000 for an individual or $170,000 for a couple.

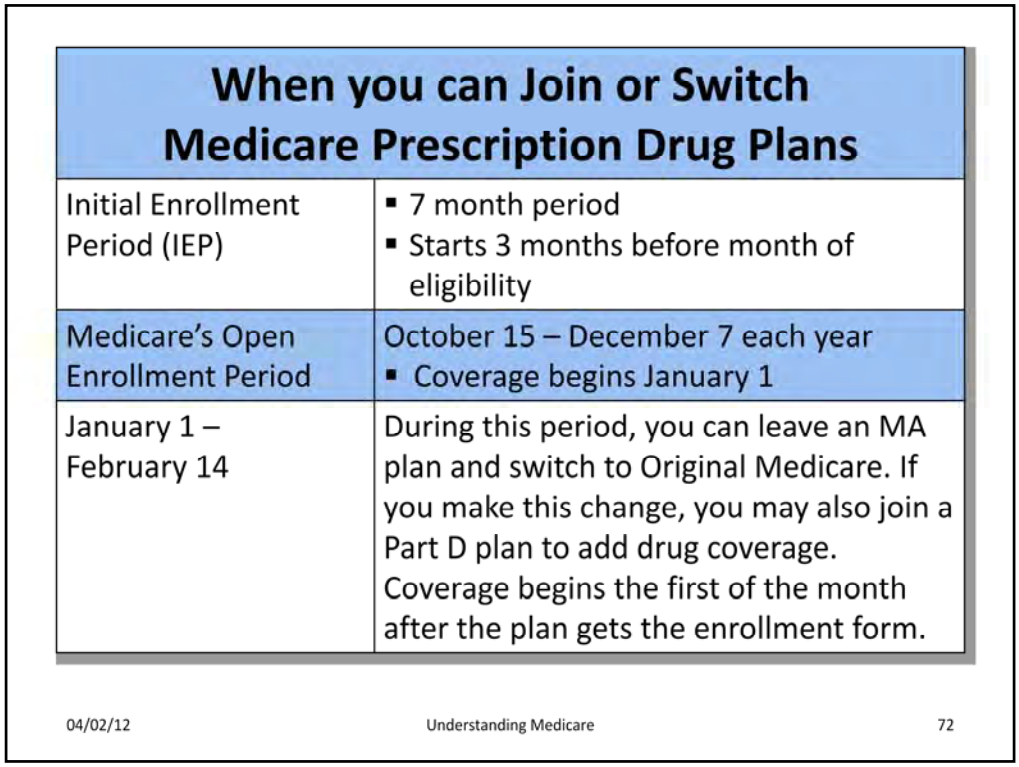
The amount of the IRMAA is adjusted each year, as it is calculated from the annual beneficiary base premium.

Anyone who has Medicare Part A and/or Part B, and lives in the plan's service area is eligible to join a Medicare drug plan. To get prescription drug coverage through a Medicare Advantage plan, generally you must have both Part A and Part B.

Each plan has its own service area, and you must live in a plan's service area to enroll. People in the U.S. territories, including the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Marianas, can enroll. If you live outside the U.S. and its territories, or are incarcerated, you are not eligible to enroll in a plan and, therefore, cannot get coverage.

Medicare prescription drug coverage is not automatic. You must enroll in a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, most must take action to get it.

You can only be a member of one Medicare drug plan at a time.

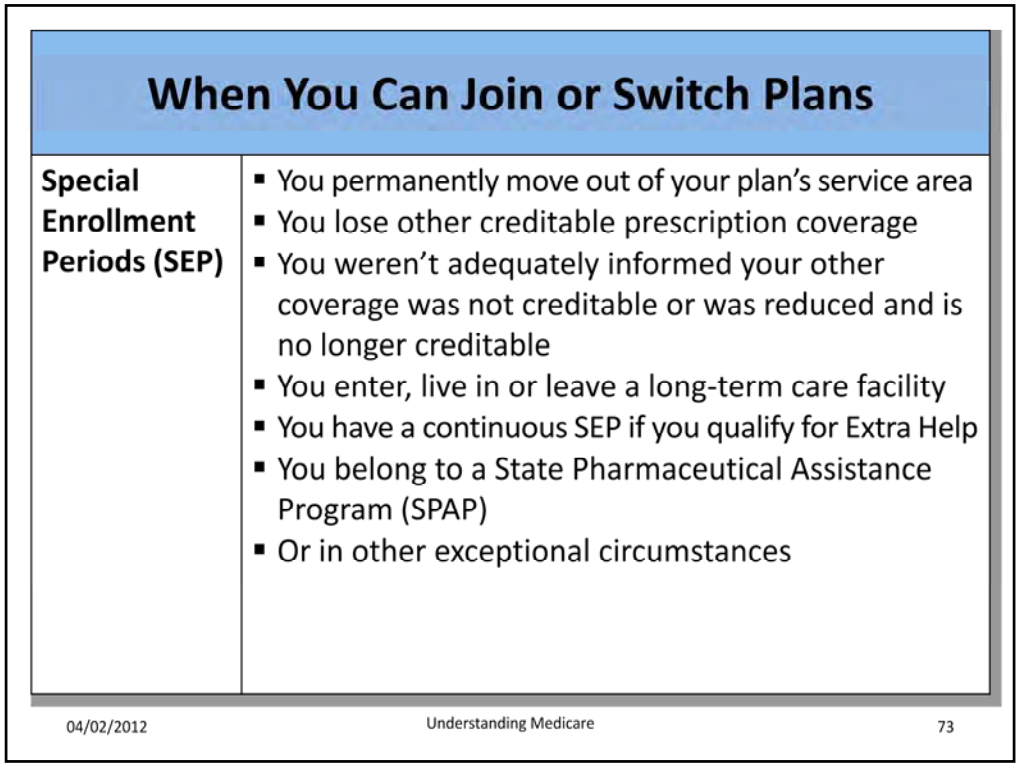


You can join a Medicare drug plan when you first become eligible for Medicare (i.e., during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B). After you enroll in a Medicare drug plan you must remain with that plan for the rest of the calendar year.

You can also enroll in a Medicare drug plan during Medicare's Open Enrollment Period (also known as Open Enrollment), October 15 – December 7 each year. You can also **change** Medicare drug plans during Open Enrollment.

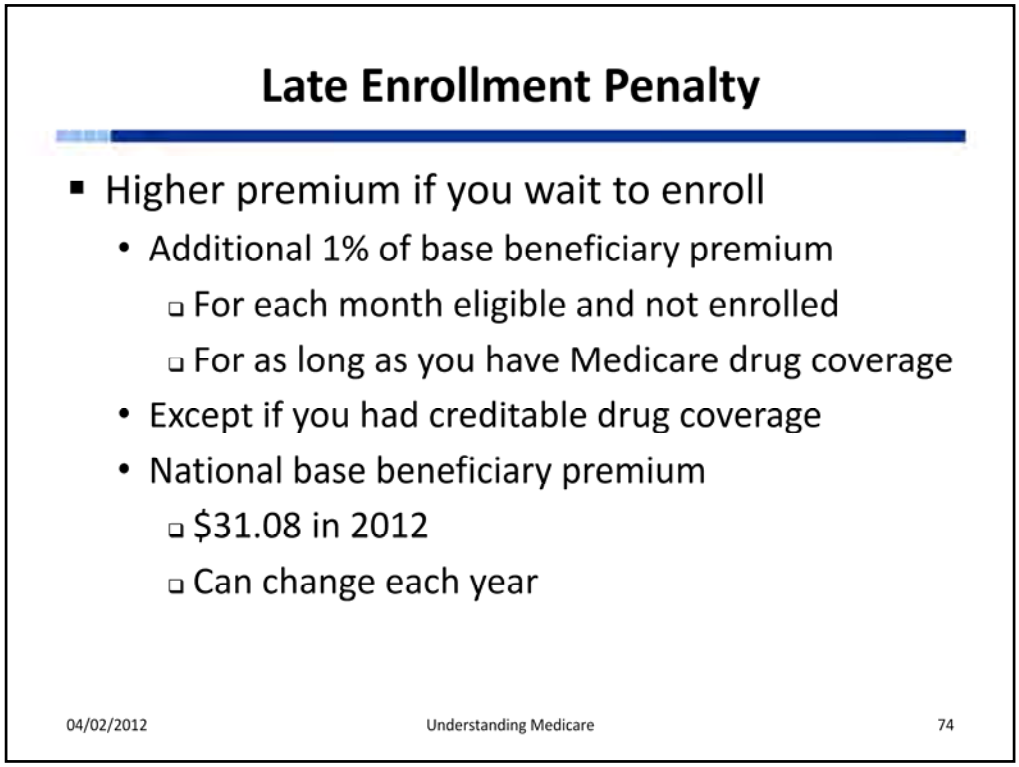
Between January 1–February 14, you can leave an MA plan and switch to Original Medicare. If you make this change, you may also join a Medicare drug plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

See Section 3204 of the Affordable Care Act.



In certain situations, you may get a Special Enrollment Period (SEP):

- If you permanently move out of your plan's service area.
- If you lose your other creditable prescription drug coverage.
- If you were not adequately informed that your other coverage was not creditable, or that the coverage was reduced so that it is no longer creditable.
- When you enter, reside in, or leave a long-term care facility like a nursing home.
- If you qualify for Extra Help, you have a continuous SEP and can change your Medicare drug plan at any time.
- You belong to a State Pharmaceutical Assistance Program (SPAP).
- Or in other exceptional circumstances, such as if you no longer qualify for Extra Help.

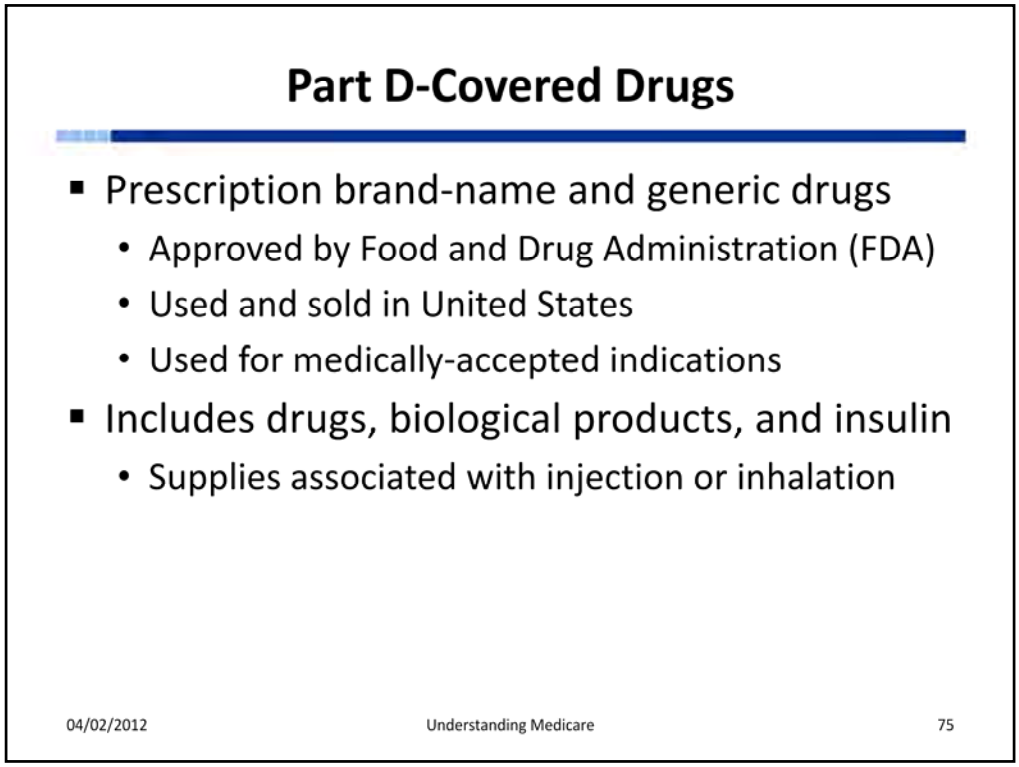


If you choose not to join a Medicare drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you decide to enroll later. The penalty is added to the premium payment amount. It is calculated by multiplying 1% of the national base beneficiary premium by the number of months you were eligible but not enrolled in a plan, and did not have creditable drug coverage. The penalty calculation is not based on the premium of the plan you are enrolled in. The base beneficiary premium ($31.08 in 2012) is a national number and can change each year.

If you have another source of drug coverage (e.g., through a former employer), you may choose to stay in that plan and not enroll in a Medicare drug plan. If your other coverage is at least as good as Medicare prescription drug coverage, called "creditable" coverage, you will not have to pay a higher premium if you later join a Medicare drug plan. You also will not have to pay a higher premium if you get Extra Help paying for your prescription drugs.

If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You will need to fill out a reconsideration request form (that your plan will send you), and you will have the chance to provide proof that supports your case, such as information about previous creditable prescription drug coverage.

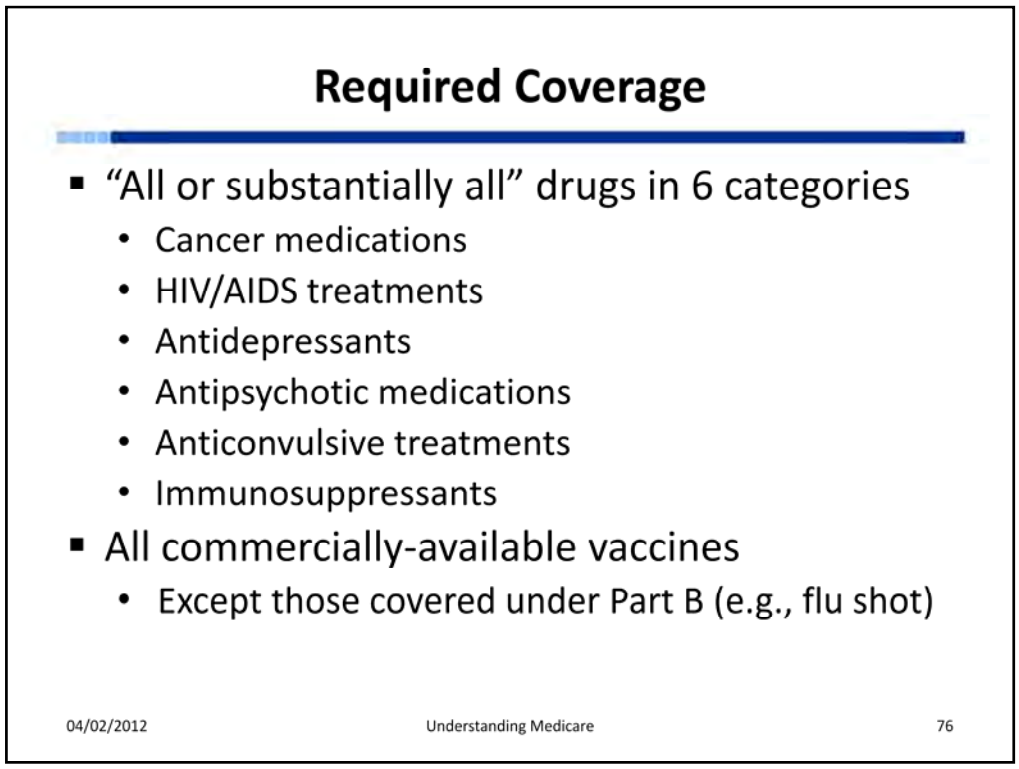
Example: Mr. Smith did not enroll in a Medicare drug plan by May 31, 2011, the end of his IEP. He did not have creditable prescription drug coverage and first enrolled in a Medicare drug plan in December 2011, during open enrollment. His penalty is 7% because he had 7 months without creditable coverage, starting with the first month he would have been covered if he had joined a plan by May 31. CMS counts June through December of 2011 (7 months). Since the national base beneficiary premium in 2012 is $31.08, the penalty would be $2.20 per month ($31.08 x .07 = $2.17, rounded to the nearest 10 cents = $2.20). In general, the penalty will be added to his premium payment, and assessed for as long as he has Medicare drug coverage. It is recalculated each year that the national base beneficiary premium changes.



Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically-accepted indication.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze, are also covered. Supplies associated with the inhalation of insulin may also be covered by Medicare drug plans.

NOTE: There are older drugs that never went through FDA approval processes. As plans review their formularies and find these drugs, they are removed from the formulary.

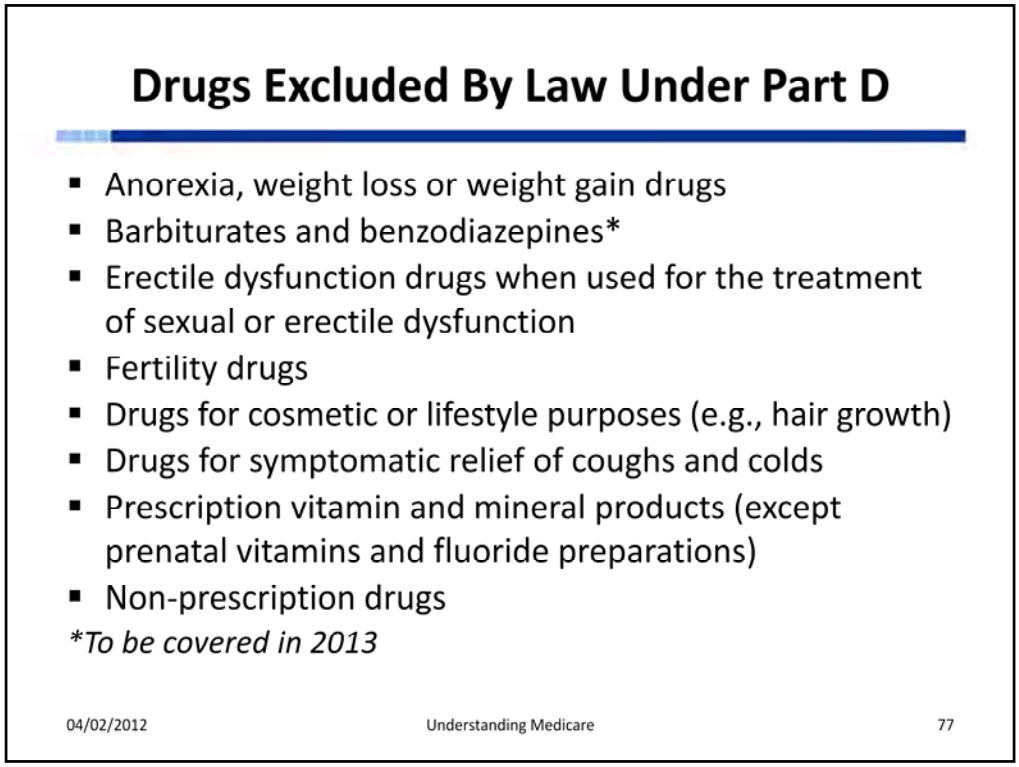


Medicare drug plans must cover "all or substantially all" drugs in 6 categories to treat certain conditions:

- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine (but not vaccines such as the flu and pneumococcal pneumonia shots that are covered under Part B).

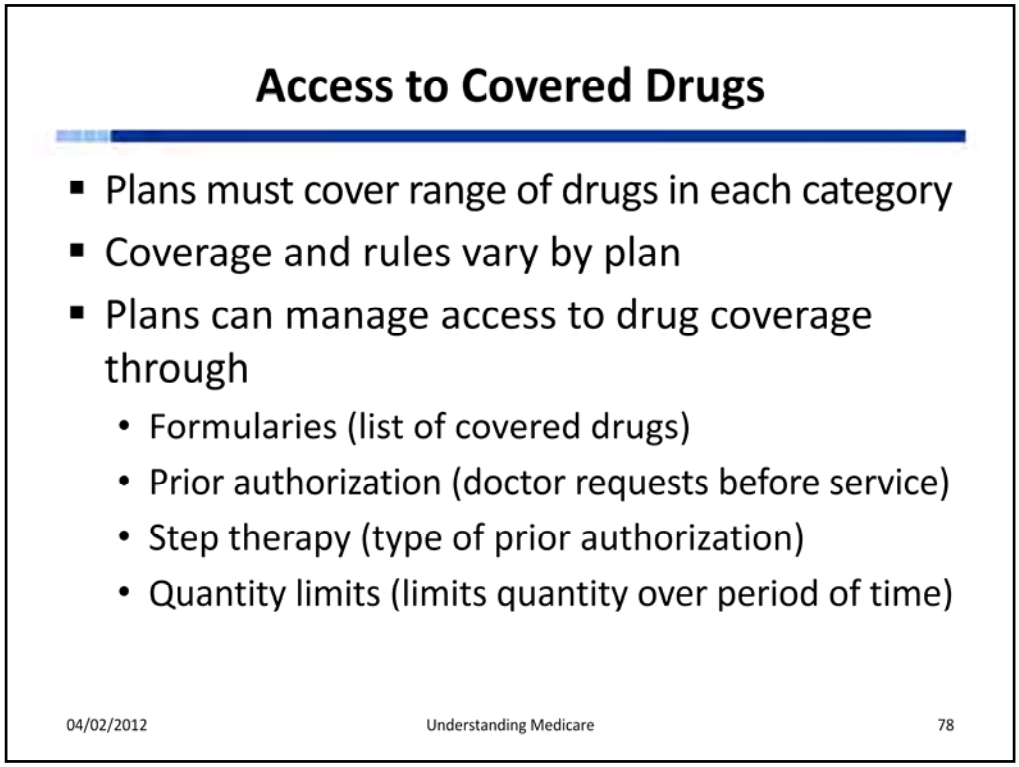
You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.



By law, Medicare doesn't cover certain drugs:

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines (will be covered starting in 2013)
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth)
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs

Plans may choose to cover excluded drugs at their own cost or share the cost with you.

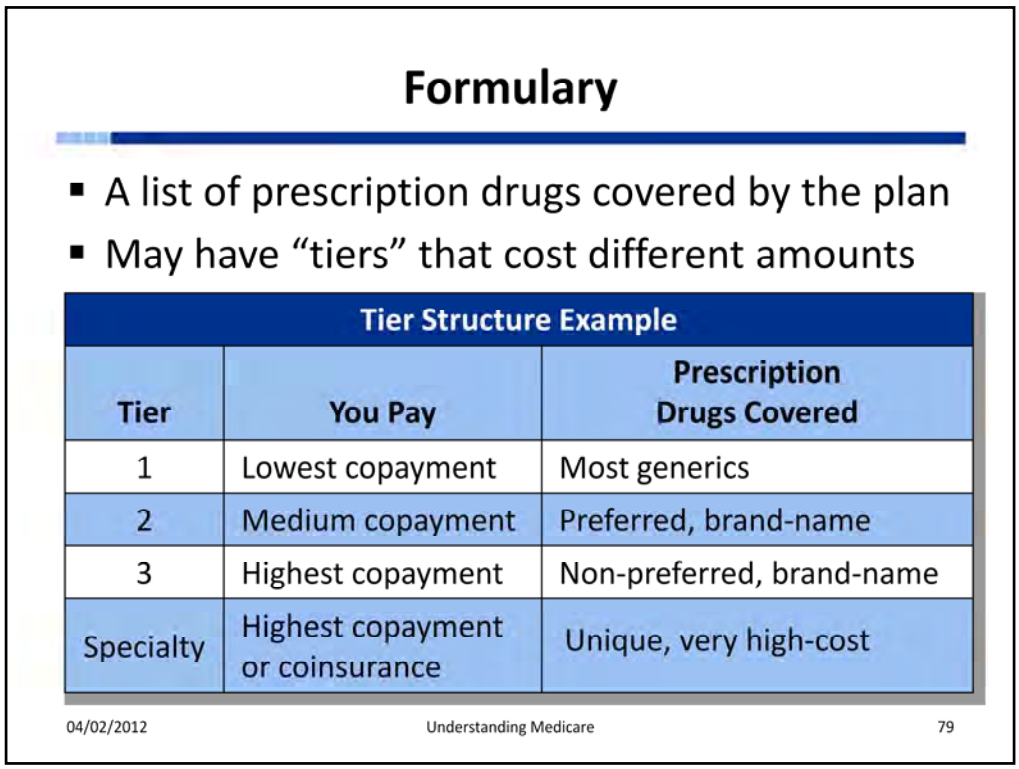


Plans must cover a range of drugs in the most commonly prescribed categories and classes. This helps make sure that people with different medical conditions can get the prescription drugs they need. The prescription drug list might not include your specific drug. However, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes none of the drugs on your plan's drug list will work for your condition, you can ask for an exception.

Coverage and rules vary by plan, which can affect what you pay.

Some of the methods (rules) that plans use to manage your access to drug coverage include:

- Formularies (list of covered drugs)
- Prior authorization (doctor requests before prescribing)
- Step therapy (type of prior authorization)
- Quantity limits (limits quantity of prescription over a period of time)

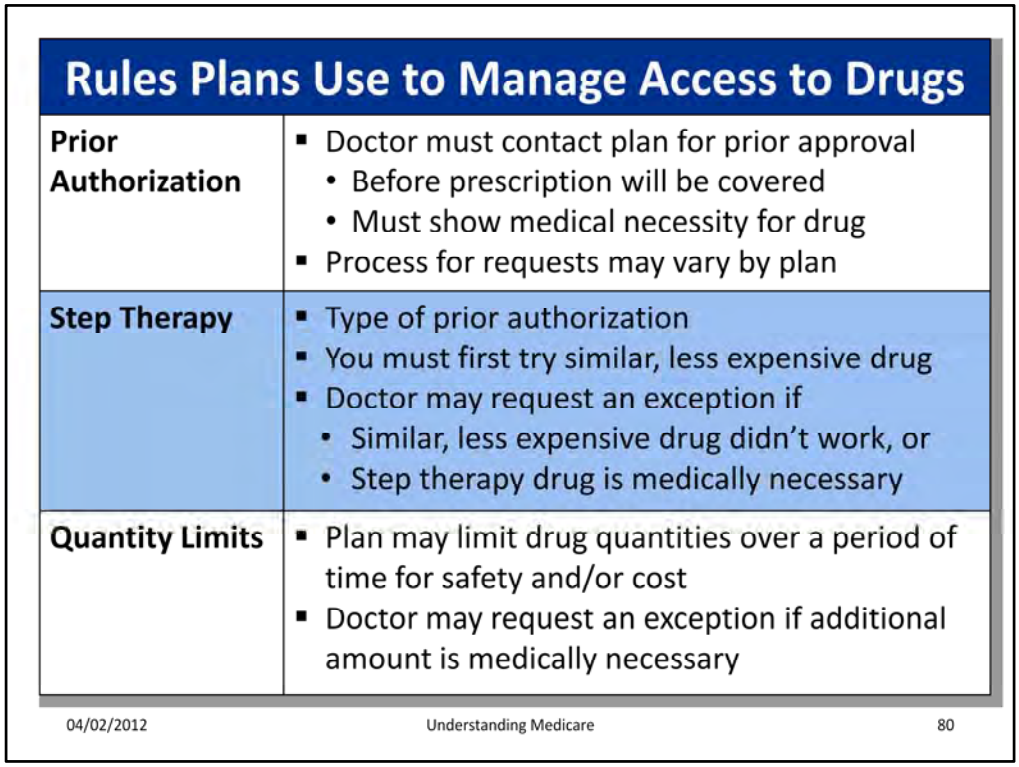


Each Medicare drug plan has a list of prescription drugs that it covers called a formulary. Plans cover both generic and brand-name prescription drugs. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form its tiers in different ways.

Here is an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive) - The Food and Drug Administration (FDA) says a generic drug is the same as its brand-name counterpart in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs. Generic drug makers must prove to the FDA that their product performs the same way as the corresponding brand-name drug. Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be FDA-approved. Today, almost half of all prescriptions in the U.S. are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2–Preferred brand-name drugs** - Tier 2 drugs will cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drugs** - Tier 3 drugs will cost more than Tier 2 drugs.
- **Specialty Tier** – These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier, and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment.



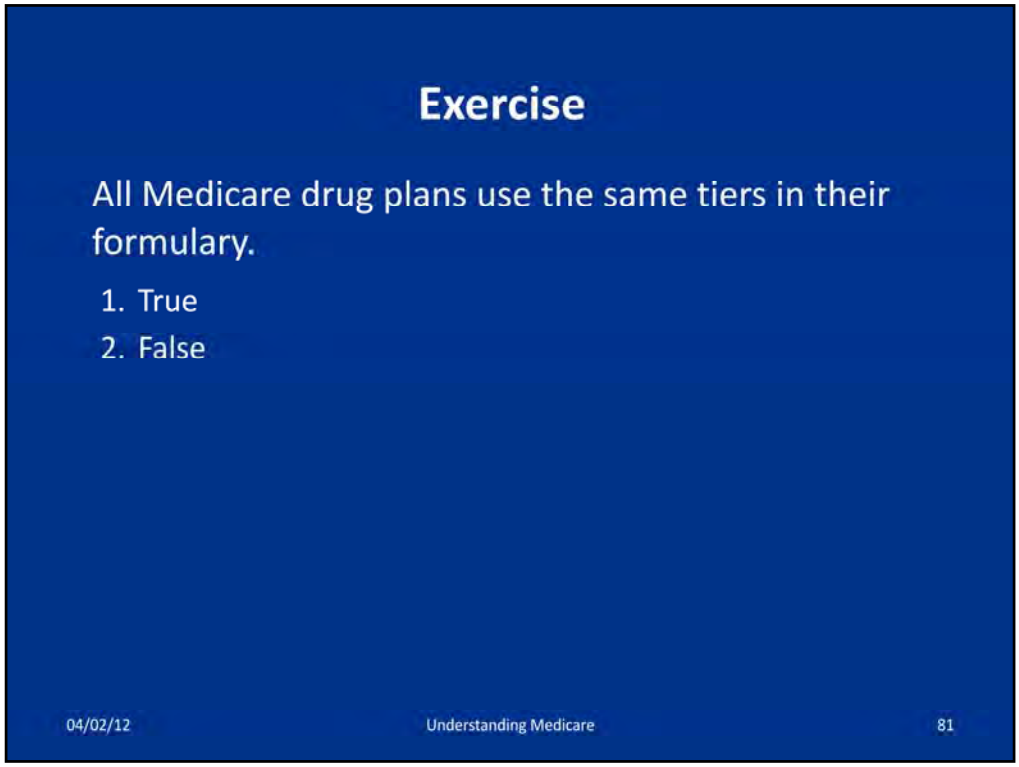
Some Medicare drug plans may have rules that require prior authorization. Prior authorization means that before the plan will cover a prescription, your doctor must first contact the plan. Your doctor has to show there is a medically-necessary reason why you must use that particular drug for it to be covered. Plans do this to be sure these drugs are used correctly and only when medically necessary.

You can request the plan's prior authorization requirements in order to understand what you will need to do to access a drug, or provide this information to your doctors. Prior authorization requirements are also available on Medicare drug plans' websites.

Step therapy is a type of prior authorization. With step therapy, in most cases, you must first try less expensive drugs that have been proven effective for most people with a specific medical condition. For example, some plans may require you to try a generic drug (if available), then a less expensive brand-name drug on their drug list, before they will cover a more expensive brand-name drug.

However, if you have already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of your medical condition, it is medically necessary to take a step therapy drug (the drug the doctor originally prescribed), you (with your doctor's help) can contact the plan to request an exception. If the request is approved, the originally prescribed step therapy drug will be covered.

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If you require more, your doctor may need to contact the plan to request an exception if he/she believes the additional amount is medically necessary. If the request is approved, the amount prescribed by your doctor will be covered.

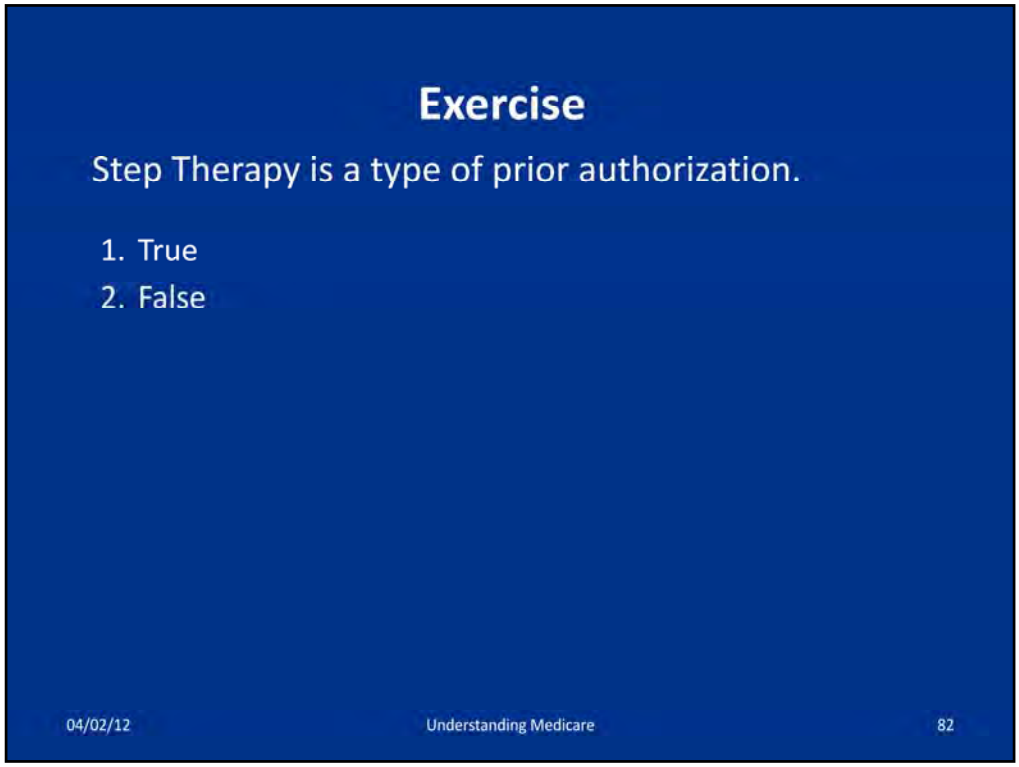


Exercise

All Medicare drug plans use the same tiers in their formulary.

1. True
2. False

Answer: 2. False.
Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form its tiers in different ways.

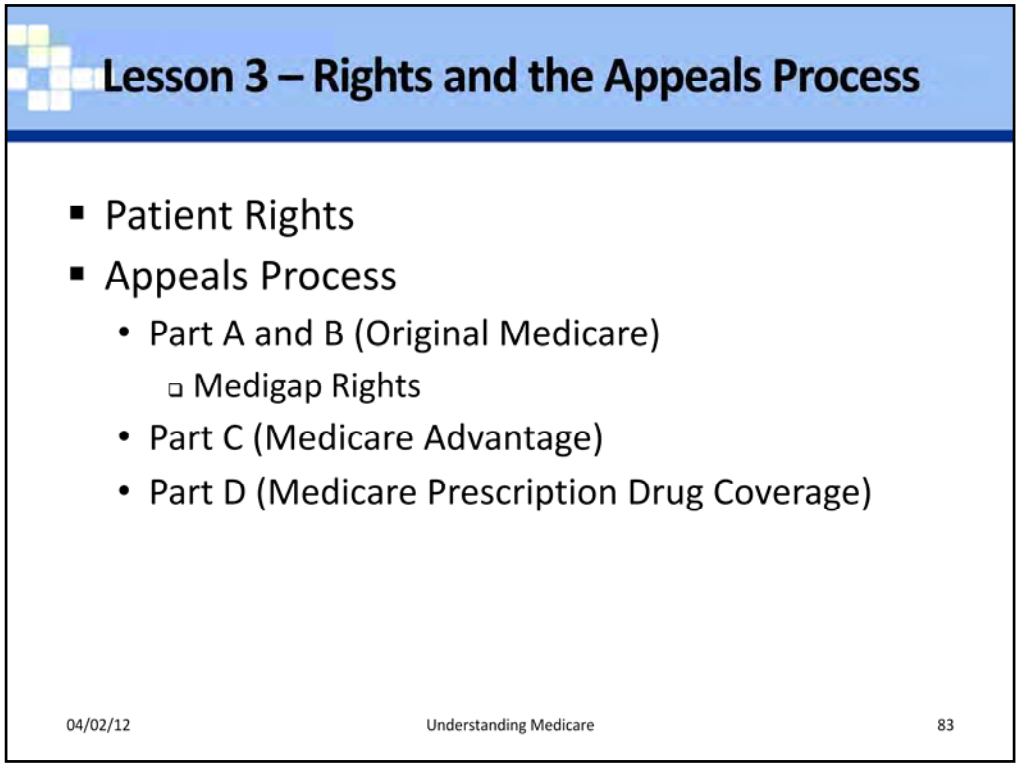


Exercise

Step Therapy is a type of prior authorization

1. True
2. False

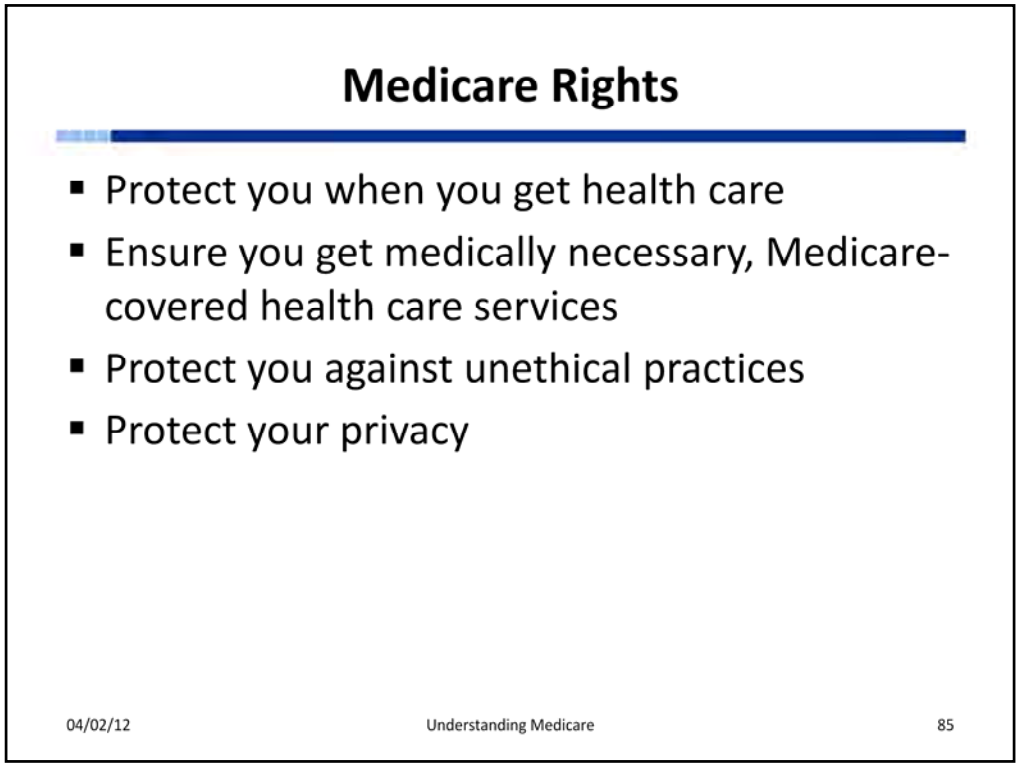
Answer: 2. True
Step therapy is a type of prior authorization. With step therapy, in most cases, you must first try less expensive drugs that have been proven effective for most people with a specific medical condition. For example, some plans may require you to try a generic drug (if available), then a less expensive brand-name drug on their drug list, before they will cover a more expensive brand-name drug.



Rights and the Appeals Process provides an overview of your Medicare rights, and the process for appealing certain decisions.

- Part A and B (Original Medicare) appeals process including Medigap rights
- Part C (Medicare Advantage) appeals process
- Part D (Medicare Prescription Drug Coverage) appeals process

You have certain guaranteed rights under the Medicare program in Original Medicare, Medicare Advantage and other health plans, and Medicare prescription drug plans.



These rights protect you when you get health care, ensure you get medically necessary Medicare-covered health care services, protect you against unethical practices, and protect your privacy.

You have the right to

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Get information about Medicare you can understand to make health care decisions
  - This includes information on what is covered, which costs are paid, how much you have to pay, and what to do to file a complaint
- Get culturally-competent services in a language you can understand and in a culturally sensitive way
- Get emergency care when and where you need it
  - Urgently needed care is care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health.
- Get your questions about Medicare answered
  - You can call 1-800-MEDICARE or contact your State Health Insurance Assistance Program. Their numbers are on www.medicare.gov and listed in the *Medicare & You* handbook, CMS Product No. 10050.

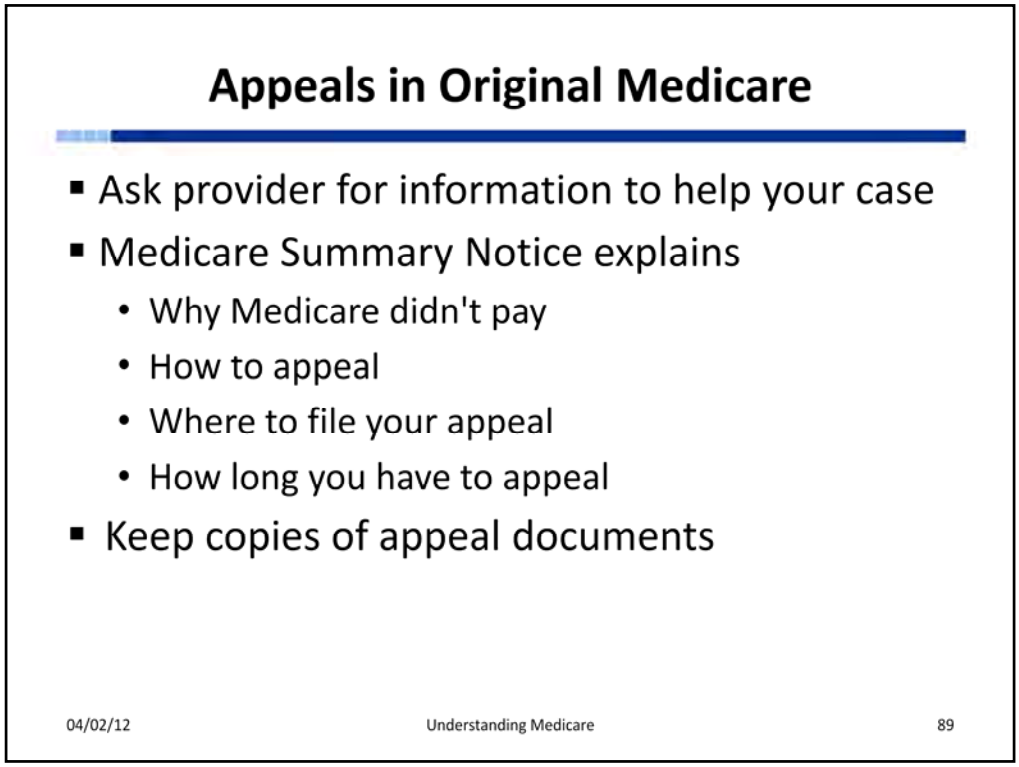
You also have the right to

- Learn about treatment choices in clear, understandable language
  - Medicare health plans cannot prevent your doctor from telling you what you need to know about your treatment choices
- File a complaint about payment, services, or other problems, including the quality of your health care
- Appeal decisions about coverage and/or payment
- Have the personal information that Medicare collects about you kept private
- Know your privacy rights

You have the right to file a complaint about concerns or problems you may have had in getting health care or the quality of the health care received.

An appeal is the action you should take if you disagree with a coverage or payment decision (i.e., Medicare should have paid but didn't, or didn't pay enough; a Medicare health plan denied a needed service; or a Medicare drug plan didn't cover a prescription drug).

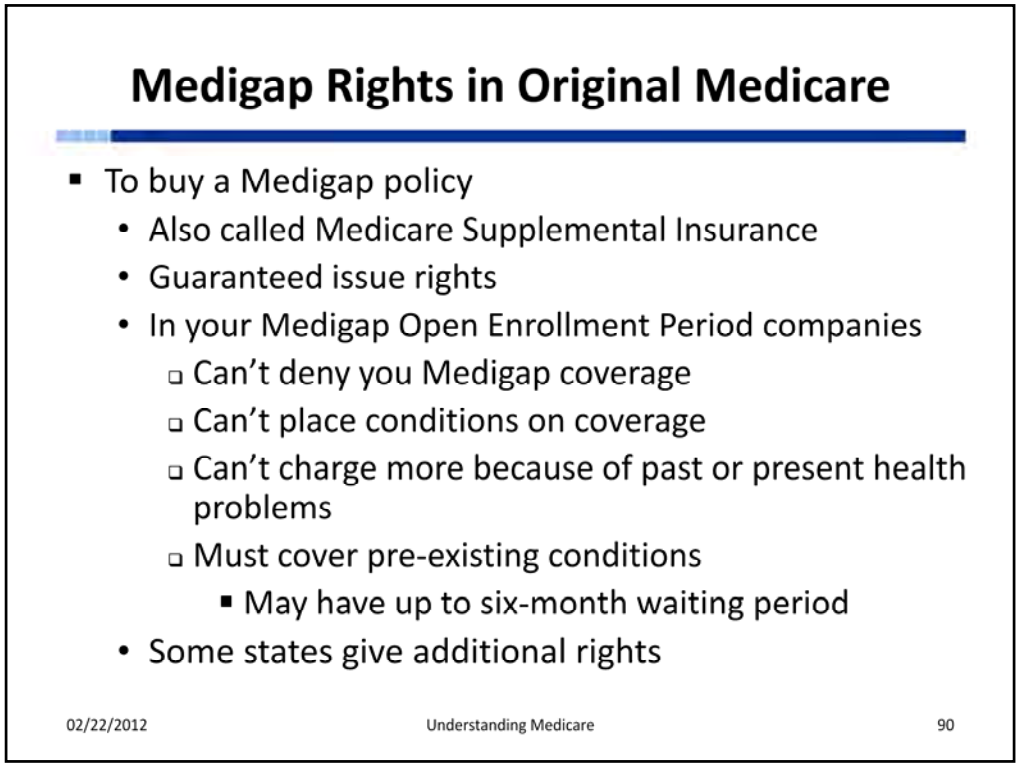
For more information on filing an appeal or complaint, call your plan, the State Health Insurance Assistance Program (SHIP) in your state, or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



In Original Medicare, you can file an appeal if you think Medicare should have paid for an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. If you have received care and you aren't sure if Medicare was billed for the items or services that you got, write or call your doctor, health care provider, or supplier and ask for an itemized statement.

Appeal instructions are on the Medicare Summary Notice (MSN) that is mailed to you by the company that handles your Medicare bills. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. It will tell you where to file the appeal and the time limit for filing your appeal.

You should keep a copy of everything you send to Medicare as part of your appeal.



Your rights when you are enrolled in Original Medicare include the following:

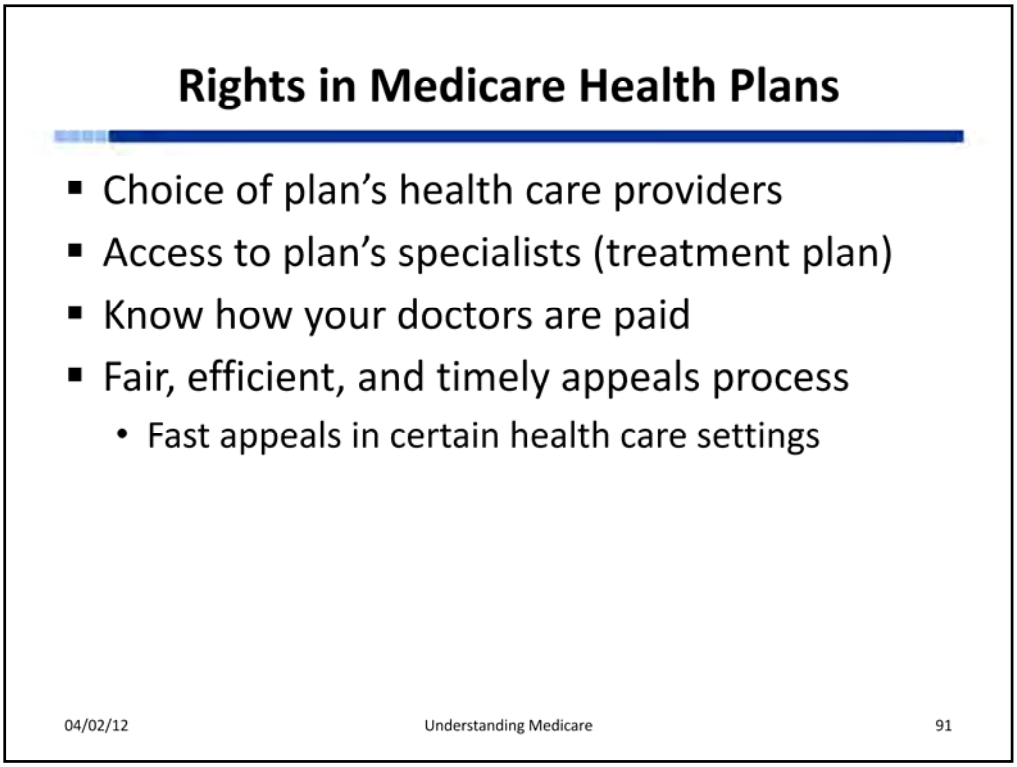
- To buy a Medigap (Medicare Supplemental Insurance) policy.
  - In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare coverage, such as coinsurance amounts.
  - Medigap policies must follow Federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
  - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a "standardized" Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N.
    - The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
  - You have the right to buy a Medigap policy during your Medigap open enrollment period (6-month period that starts when your are both age 65 and are enrolled in Part B). While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage of a pre-existing condition.

When you have guaranteed issue rights, the Medigap plan

- Can't deny you Medigap coverage or place conditions on your policy
- Must cover you for pre-existing conditions
- Can't charge you more for a policy because of past or present health problems

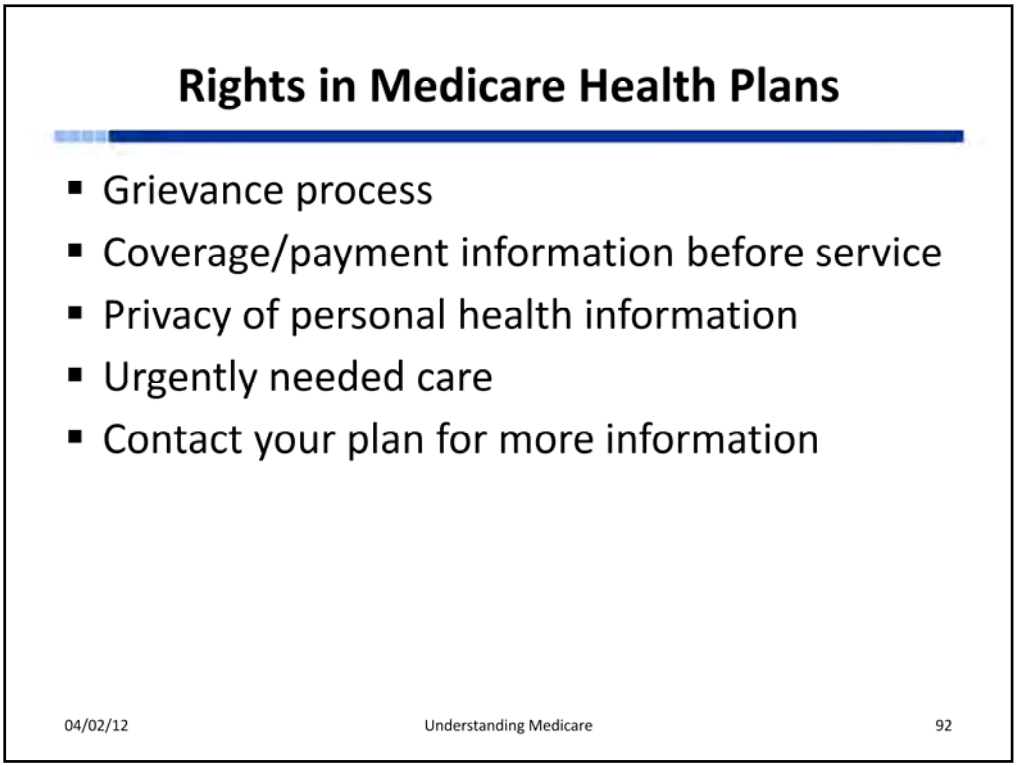
Some states offer additional rights to purchase Medigap policies.

Note: Module 3, *Medigap*, describes these situations.



If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the right to:

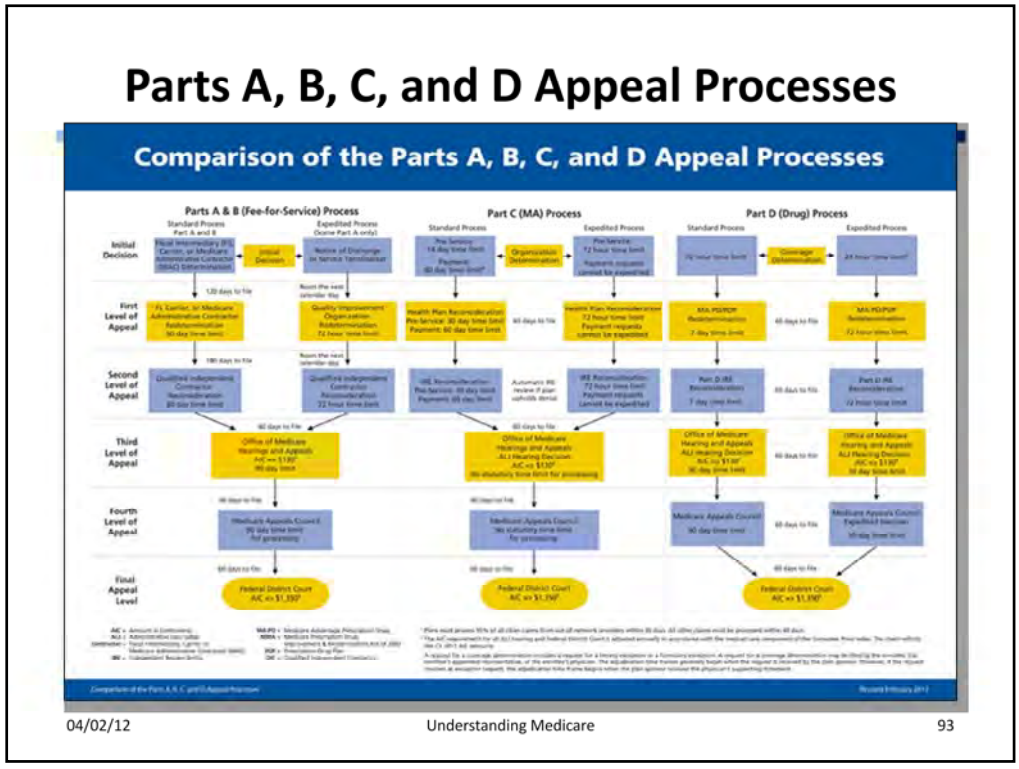
- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.
- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- A fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.



If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the following rights:

- To file a grievance about other concerns or problems with your plan (e.g., if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs). Check your plan's membership materials or call your plan to find out how to file a grievance.
- To get a coverage decision, or coverage information from your plan before getting services to find out if it will be covered, or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
- To privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.
- To urgently needed care, which is the care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health. If you are in a Medicare health plan, health care providers in the plan's network generally provide care if you are in the plan's service area. If you are out of your plan's service area for a short time (less than 6 months) and cannot wait until you return home, the health plan must pay for urgently needed care.

For more information about your rights and protections, read your plan's membership materials or call your plan.

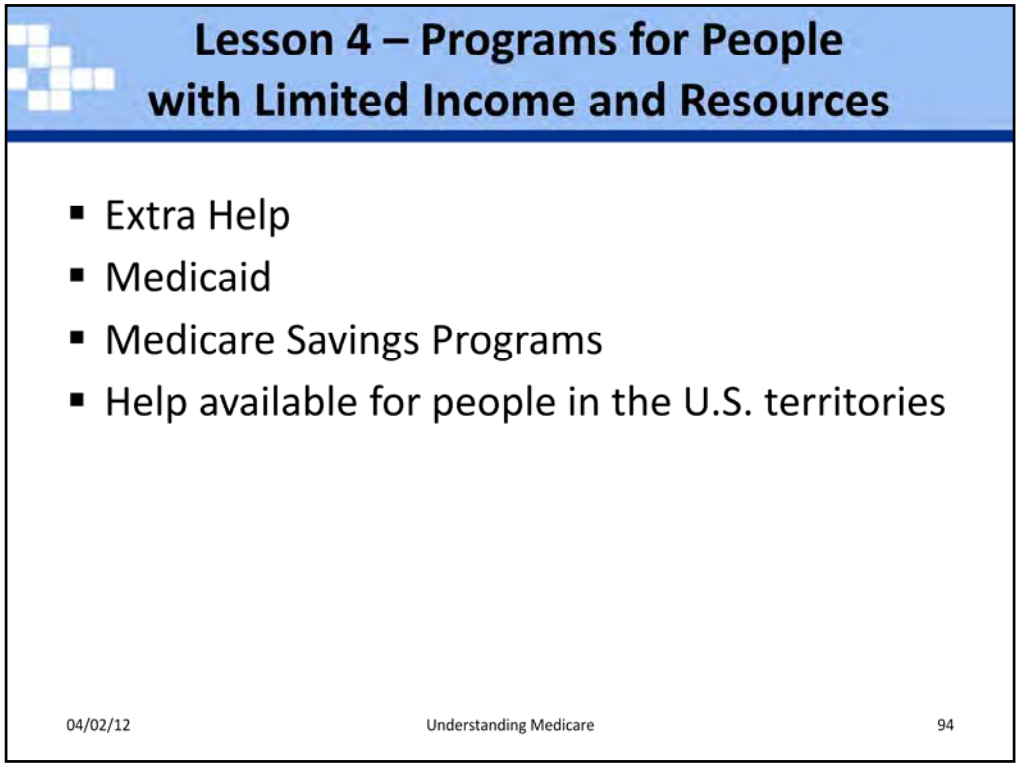


This chart shows the appeals process in Parts A, B, C, and D of Medicare.

For more information about appeals, go to www.medicare.gov and view the publication *Your Medicare Rights and Protections*, CMS Product No. 10112.

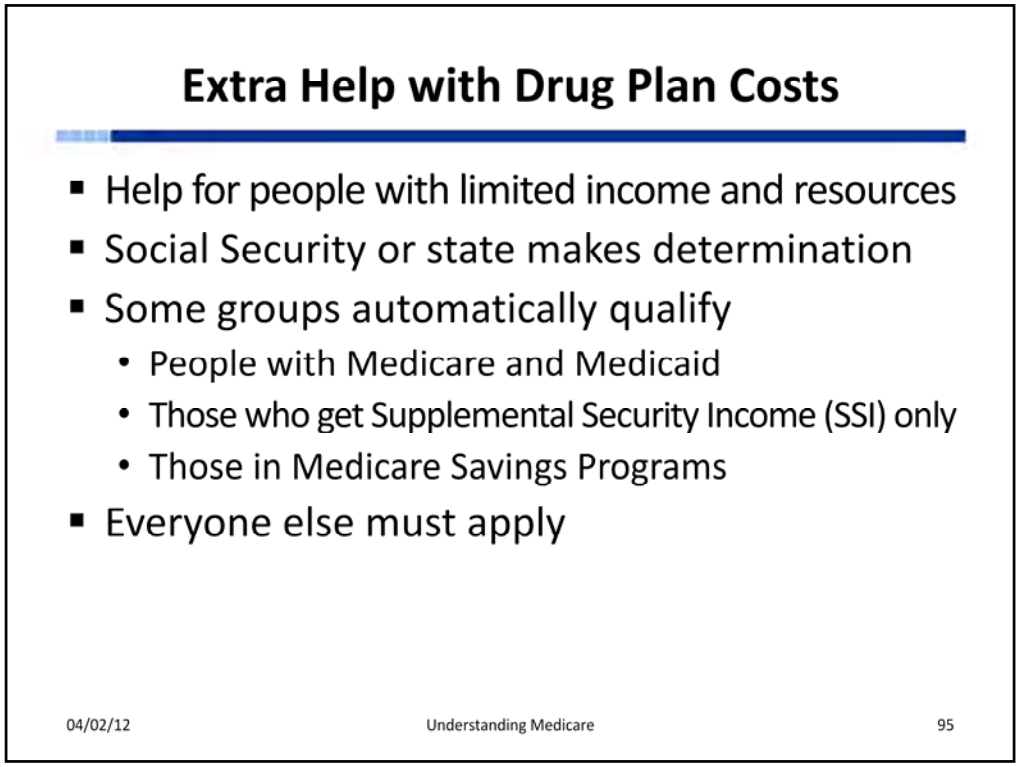
Module 2 explains appeals in more detail.

NOTE: A full size copy of this chart is provided in the corresponding workbook. See Appendix C.



Lesson 4 *Programs for People with Limited Income and Resources* explains

- Extra Help
- Medicaid
- Medicare Savings Programs
- Help available for people who live in the U.S. territories



People with Medicare who have limited incomes and resources may be able to get Extra Help with the costs of Medicare prescription drug coverage. You must be enrolled in a Medicare prescription drug plan to get Extra Help.

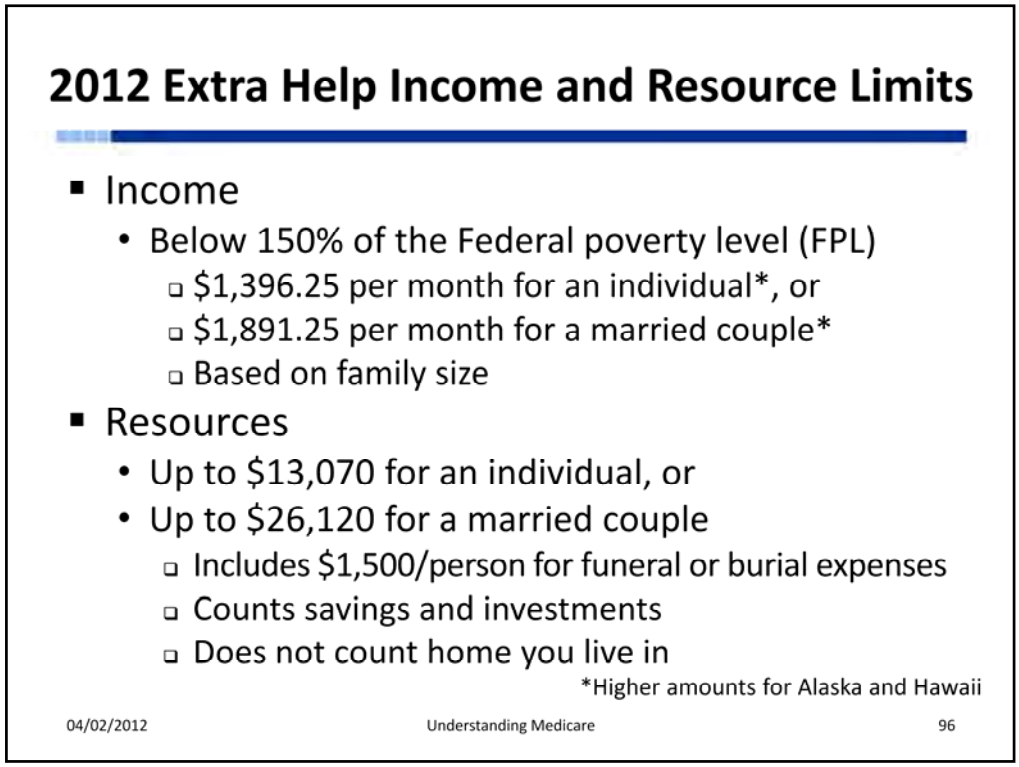
You can apply with either Social Security or your state's Medicaid program office. When you apply, you will be asked for information about your income and resources, and you will be asked to sign a statement that your answers are true. Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.

When your application has been processed, you will get a letter telling you if you qualify for Extra Help.

Certain groups of people automatically qualify for Extra Help and do not have to apply. These include:

- People with Medicare and full Medicaid benefits (including prescription drug coverage)
- People with Medicare who get Supplemental Security Income only (SSI)
- People who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs)

All other people with Medicare must file an application to get Extra Help.

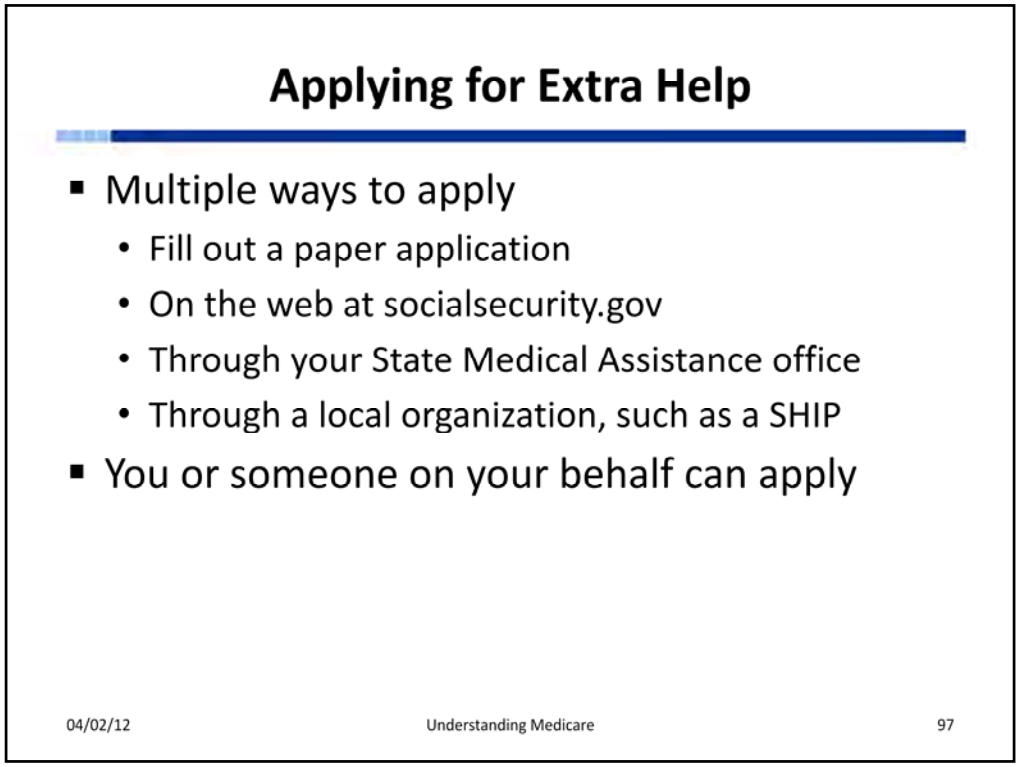


Extra Help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources.

Medicare counts the income of you and your spouse (living in the same household), regardless of whether or not your spouse is applying for Extra Help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Resources also are counted for you and a spouse (living with you). Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, burial expenses up to your state's limit, furniture, or other household items, wedding rings or family heirlooms.

NOTE: Extra Help isn't available to people in the U.S. territories. The territories have their own rules for providing help with Medicare drug plan costs to their residents.

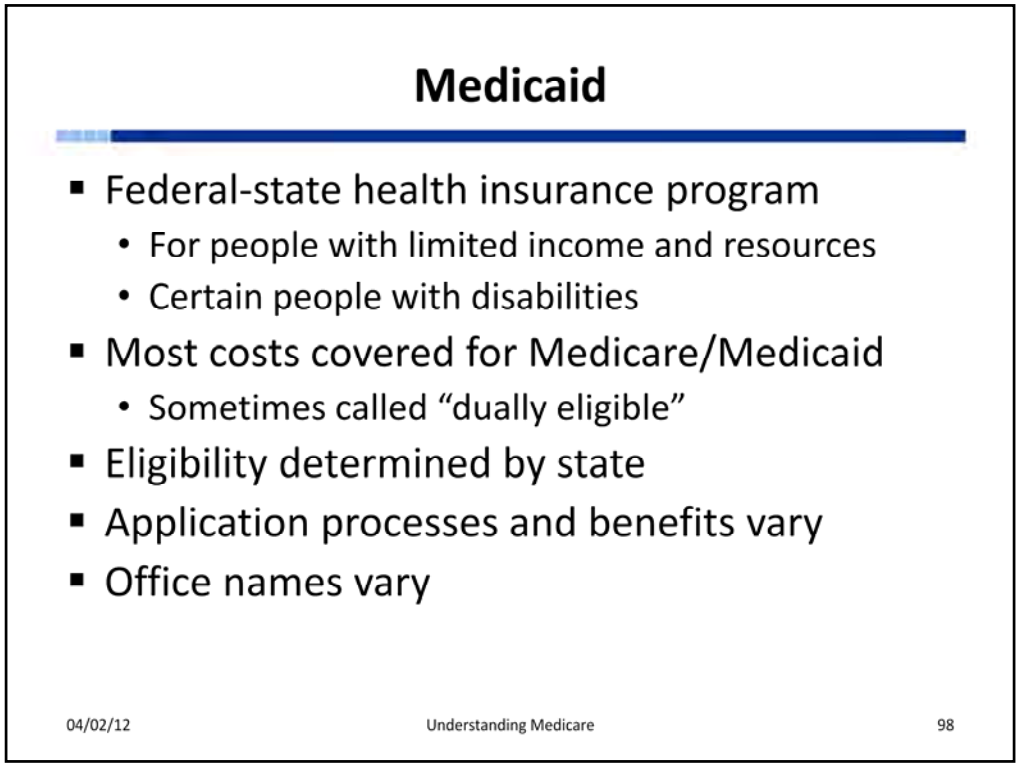


You can apply for Extra Help by

- Completing a paper application that you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
- Applying with Social Security at www.socialsecurity.gov
- Applying through your state Medical Assistance office
- Working with a local organization, such as your State Health Insurance Assistance Program (SHIP)

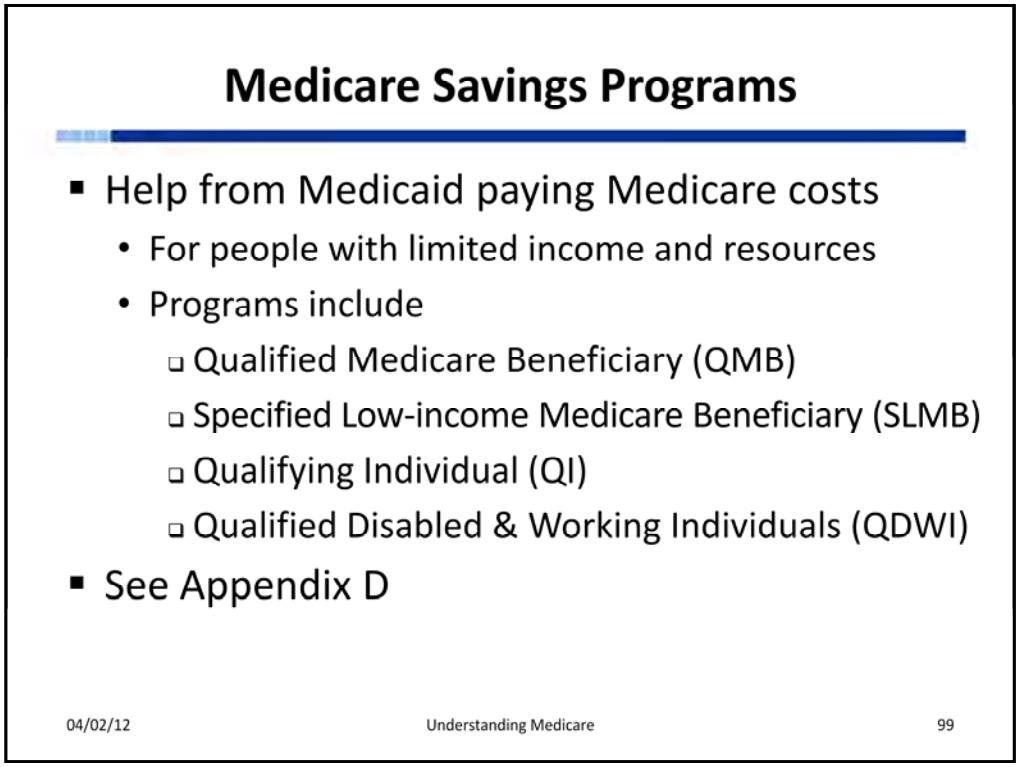
You can apply on your own behalf, or your application can be filed by a personal representative with the authority to act on your behalf, such as Power of Attorney, or you can ask someone else to help you apply.

Under Section 113 of MIPPA, Social Security is directed to transmit data from the LIS application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for Medicare Savings Programs (MSP). The states are directed to treat the data as an application for MSP benefits, as if it had been submitted directly by the applicant.



Medicaid is a program that helps pay medical costs for some people with limited income and resources. Medicaid is jointly funded by the Federal and state government and is administered by each state. It can cover children; aged, blind, and disabled people; and some other groups, depending on the state. If you are eligible for both Medicare and Medicaid, most of your health care costs are covered; we often refer to these people as "dually eligible." People with both Medicare and Medicaid get drug coverage from Medicare, not Medicaid. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home care and home health care.

Medicaid eligibility is determined by each state, and Medicaid application processes and benefits vary from state to state. You need to contact your state Medical Assistance office to see if you qualify. For instance, a person in *Name of State*, would apply for Medicaid at *Name of Agency*. *[Instructor: insert information specific to Medicaid in your state.]*



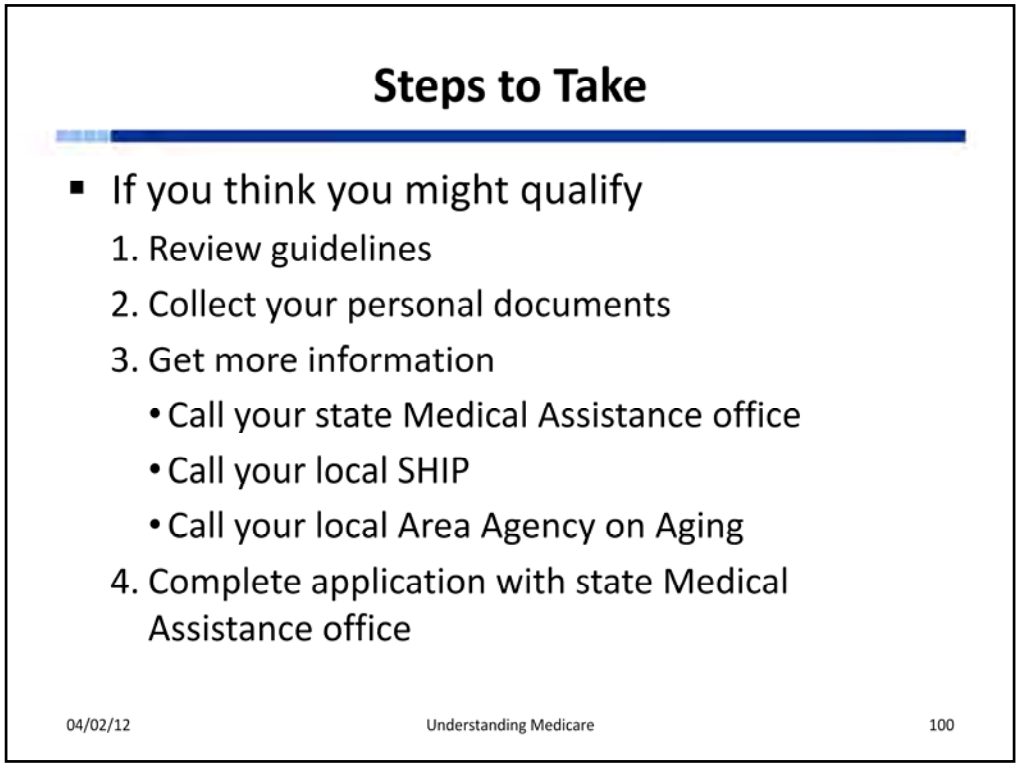
States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid. These programs are collectively called Medicare Savings Programs, and include the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs. See Appendix D for a chart with more detailed information on these programs.

Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.

Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.

Under Section 113 of MIPPA, Social Security is directed to transmit data from the LIS application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for Medicare Savings Programs (MSP). The state is directed to treat the data as an application for MSP benefits, as if it had been submitted directly by the applicant.

Contact your State Health Insurance Assistance Program (SHIP) to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses.

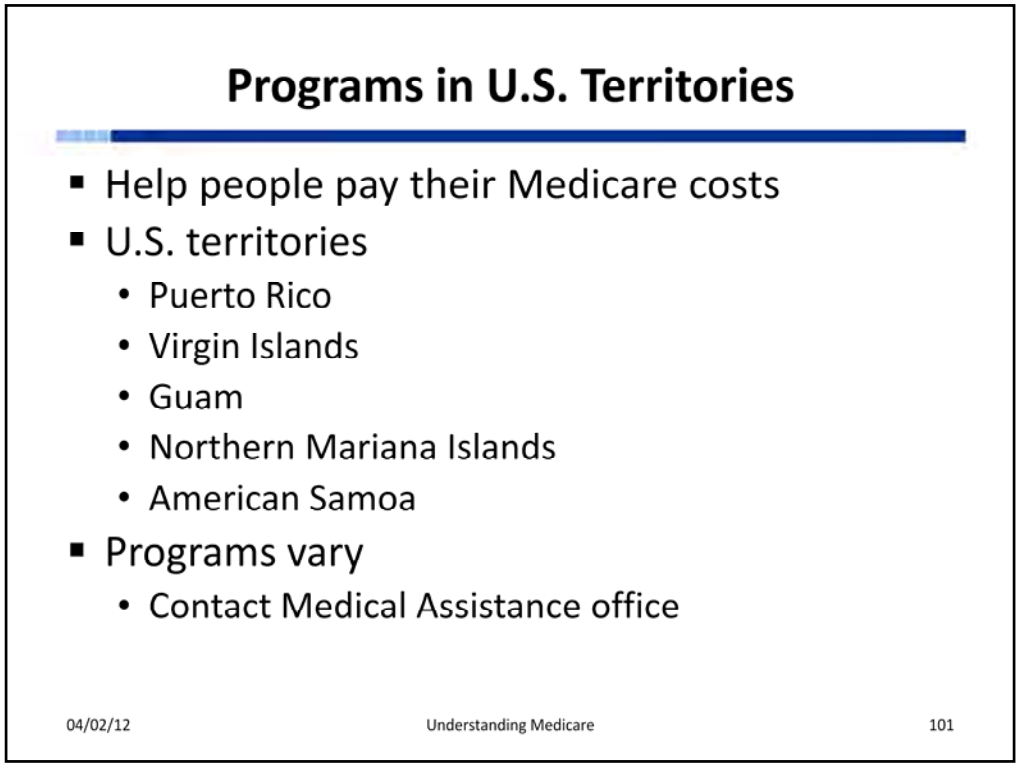
First, review the income and resource (or asset) guidelines for your area.

If you think you may qualify, collect the personal documents the agency requires for the application process. You will need

- Your Medicare card
- Proof of identity
- Proof of residence
- Proof of any income, including pension checks, Social Security payments, etc.
- Recent bank statements
- Property deeds
- Insurance policies
- Financial statements for bonds or stocks
- Proof of funeral or burial policies

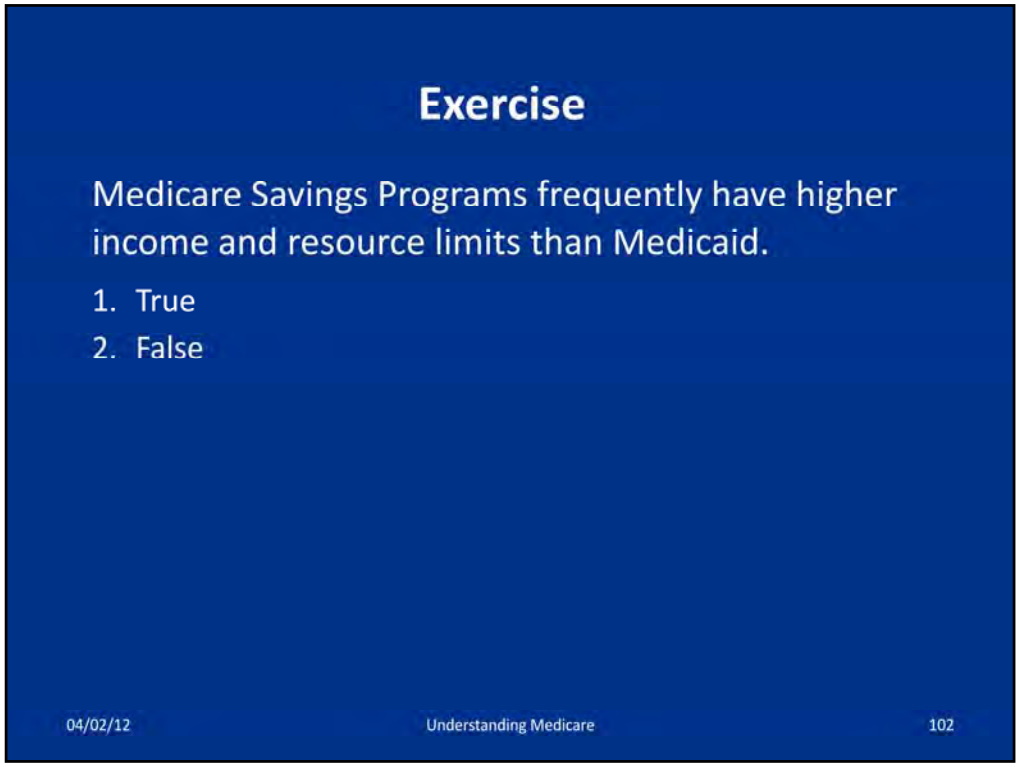
You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.

Finally, complete an application with your state Medical Assistance office.



There are also programs available to help people with limited income and resources who live in the U.S. territories—Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa—pay their Medicare costs. Programs vary in these areas. Contact the Medical Assistance office in the territory for more information.

NOTE: If none of these territories is in your area, you may wish to hide this slide.



Exercise

Medicare Savings Programs frequently have higher income and resource limits than Medicaid

1. True
2. False

Answer: 1. True.
Medicare Savings Programs help pay out-of-pocket costs for people who have limited income and resources and frequently have higher income and resource limits than Medicaid.

Introduction to Medicare Resource Guide

Resources		Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.medicare.gov www.CMS.gov **Social Security** 1-800-772-1213 TTY 1-800-325-0778 **http://www.socialsecurity.gov/** **Railroad Retirement Board** 1-877-772-5772 http://www.rrb.gov/	**State Health Insurance Assistance Programs (SHIPs)*** *For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users http://www.medicare.gov/caregivers/ http://www.HealthCare.gov http://www.pcip.gov http://www.Benefits.gov http://www.Insurekidsnow.gov **Affordable Care Act** www.healthcare.gov/law/full/index.html	***Medicare & You Handbook*** CMS Product No. 10050 ***Your Medicare Benefits*** CMS Product No. 10116 ***Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*** CMS Product No. 02110 **To access these products** View and order single copies at www.medicare.gov Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.

This training module is provided by the

National Medicare
TRAINING PROGRAM

For questions about training products, e-mail
NMTP@cms.hhs.gov

To view all available NMTP materials
or to subscribe to our listserv, visit
www.cms.gov/NationalMedicareTrainingProgram

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**

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
National Medicare TRAINING PROGRAM
CENTERS FOR MEDICARE & MEDICAID SERVICES
...helping people with Medicare make informed health care decisions

PART D BENEFIT PARAMETERS

Part D Benefit Parameters	2006	2007	2008	2009	2010	2011	2012
Standard Benefit Design Parameters							
Deductible	$250.00	$265.00	$275.00	$295.00	$310.00	$310.00	$320.00
Initial Coverage Limit	$2,250.00	$2,400.00	$2,510.00	$2,700.00	$2,830.00	$2,840.00	$2,930.00
Out-of-Pocket Threshold	$3,600.00	$3,850.00	$4,050.00	$4,350.00	$4,550.00	$4,550.00	$4,700.00
Total Covered Part D Drug Spend at OOP Threshold	$5,100.00	$5,451.25	$5,726.25	$6,153.75	$6,440.00	$6,447.50	$6,657.50
Minimum Cost-sharing in Catastrophic Coverage							
Generic/Preferred Multi-source Drug	$2.00	$2.15	$2.25	$2.40	$2.50	$2.50	$2.60
Other	$5.00	$5.35	$5.60	$6.00	$6.30	$6.30	$6.50
Part D Full Benefit Dual Eligible Parameters							
Copayments for Institutionalized Beneficiaries	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Copayments for People with Home and Community-based Services	N/A	N/A	N/A	N/A	N/A	N/A	$0.00
Maximum Copayments for Non-institutionalized Beneficiaries							
Up to or at 100% FPL							
Up to Out-of-Pocket Threshold							
Generic/Preferred Multi-source Drug	$1.00	$1.00	$1.05	$1.10	$1.10	$1.10	$1.10
Other	$3.00	$3.10	$3.10	$3.20	$3.30	$3.30	$3.30
Above Out-of-Pocket Threshold	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Over 100% FPL							
Up to Out-of-Pocket Threshold							
Generic/Preferred Multi-source Drug	$2.00	$2.15	$2.25	$2.40	$2.50	$2.50	$2.60
Others	$5.00	$5.35	$5.60	$6.00	$6.30	$6.30	$6.50
Above Out-of-Pocket Threshold	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters							
See Resources Table							
Maximum Copayments up to Out-of-Pocket Threshold							
Generic/Preferred Multi-source Drug	$2.00	$2.15	$2.25	$2.40	$2.50	$2.50	$2.60
Other	$5.00	$5.35	$5.60	$6.00	$6.30	$6.30	$6.50
Above Out-of-Pocket Threshold	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
See Resources Table							
Deductible	$50.00	$53.00	$56.00	$60.00	$63.00	$63.00	$65.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%	15%	15%	15%	15%	15%
Maximum Copayments above Out-of-Pocket Threshold							
Generic/Preferred Multi-source Drug	$2.00	$2.15	$2.25	$2.40	$2.50	$2.50	$2.60
Others	$5.00	$5.35	$5.60	$6.00	$6.30	$6.30	$6.50

Part D Benefit Parameters	2006	2007	2008	2009	2010	2011	2012
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters							
Deductible	$50.00	$53.00	$56.00	$60.00	$63.00	$63.00	$65.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%	15%	15%	15%	15%	15%
Maximum Copyments above Out-of-Pocket Threshold							
Generic/Preferred Multi-source Drug	$2.00	$2.15	$2.25	$2.40	$2.50	$2.50	$2.60
Other	$5.00	$5.35	$5.60	$6.00	$6.30	$6.30	$6.50
Part D Full Benefit Dual Eligible Parameters							
Copayments for Institutionalized Beneficiaries	$250.00	$265.00	$275.00	$295.00	$310.00	$310.00	$320.00
Above Out-of-Pocket Threshold	$5,000.00	$5,350.00	$5,600.00	$6,000.00	$6,300.00	$6,300.00	$6,500.00

Resource Table

LIS Level	Martial Status	2006 LIS Resource Limit	2007 LIS Resource Limit	2008 LIS Resource Limit	2009 LIS Resource Limit	2010 LIS Resource Limit	2011 LIS Resource Limit	2012 LIS Resource Limit
Full Subsidy LIS	Single	$7,500.00	$7,620.00	$7,790.00	$8,100.00	$8,100.00	$8,180.00	$8,440.00
	Married	$12,000.00	$12,190.00	$12,440.00	$12,910.00	$12,910.00	$13,020.00	$13,410.00
All Other LIS	Single	$11,500.00	$11,710.00	$11,990.00	$12,510.00	$12,510.00	$12,640.00	$13,070.00
	Married	$23,000.00	$23,410.00	$23,970.00	$25,010.00	$25,010.00	$25,260.00	$26,120.00

Catastrophic Coverage
Once you reach your plan's out-of-pocket limit during the coverage gap, you automatically get "catastrophic coverage." Catastrophic coverage assures that once you have spent up to your plan's out-of-pocket limit for covered drugs, you only pay a small coinsurance amount or a copayment for the rest of the year.

Coinsurance
An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%). In a Medicare Prescription Drug Plan or Medicare Health Plan, the coinsurance will vary depending on how much you have spent.

Coverage Gap
Medicare drug plans may have a "coverage gap," which is sometimes called the "donut hole." This means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your drugs (up to a limit). Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium.

Note: If you get extra help paying your drug costs, you won't have a coverage gap. However, you will probably have to pay a small copayment or coinsurance amount.

Deductible
The amount you must pay for health care or prescriptions, before Original Medicare, your Medicare drug plan, your Medicare Health Plan, or your other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Full Benefit Dual Eligible
People who qualify for both Medicare and Medicaid.

Initial Coverage Limit
Once you have met your yearly deductible, and until you reach the plan's out-of-pocket maximum, you pay a copayment (a set amount you pay) or coinsurance (a percentage of the total cost) for each covered drug.

Out-of-Pocket Threshold
The health or prescription drug costs that you must pay on your own because they are not covered by Medicare or other insurance. The expenses that count toward a person's Medicare drug plan out-of-pocket threshold of $4,700 (for 2012).

Reference: http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CombinedCallLetter.pdf

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Comparison of the Parts A, B, C, and D Appeal Processes

	Parts A & B (Fee-for-Service) Process		Part C (MA) Process		Part D (Drug) Process		
	Standard Process Part A and B	Expedited Process (Some Part A only)	Standard Process	Expedited Process	Standard Process		Expedited Process
Initial Decision	Fiscal Intermediary (FI), Carrier, or Medicare Administrative Contractor (MAC) Determination	Initial Decision / Notice of Discharge or Service Termination	Pre-Service: 14 day time limit Payment: 60 day time limit[A]	Organization Determination / Pre-Service: 72 hour time limit Payment requests cannot be expedited	72 hour time limit[C]	Coverage Determination	24 hour time limit[C]
	120 days to file	Noon the next calendar day					
First Level of Appeal	FI, Carrier, or Medicare Administrative Contractor Redetermination 60 day time limit	Quality Improvement Organization Redetermination 72 hour time limit	Health Plan Reconsideration Pre-Service: 30 day time limit Payment: 60 day time limit	60 days to file / Health Plan Reconsideration 72 hour time limit Payment requests cannot be expedited	MA-PD/PDP Redetermination 7 day time limit	60 days to file	MA-PD/PDP Redetermination 72 hour time limit
	180 days to file	Noon the next calendar day					
Second Level of Appeal	Qualified Independent Contractor Reconsideration 60 day time limit	Qualified Independent Contractor Reconsideration 72 hour time limit	IRE Reconsideration Pre-Service: 30 day limit Payment: 60 day limit	Automatic IRE review if plan upholds denial / IRE Reconsideration 72 hour time limit Payment requests cannot be expedited	Part D IRE Reconsideration 7 day time limit	60 days to file	Part D IRE Reconsideration 72 hour time limit
	60 days to file	60 days to file	60 days to file	60 days to file			
Third Level of Appeal	Office of Medicare Hearings and Appeals AIC => $130[B] 90 day limit		Office of Medicare Hearings and Appeals ALJ Hearing Decision AIC =≥ $130[B] No statutory time limit for processing		Office of Medicare Hearing and Appeals ALJ Hearing Decision AIC =≥ $130[B]	60 days to file	Office of Medicare Hearing and Appeals ALJ Hearing Decision AIC =≥ $130[B] 10 day time limit
	60 days to file		60 days to file				
Fourth Level of Appeal	Medicare Appeals Council 90 day time limit for processing		Medicare Appeals Council No statutory time limit for processing		Medicare Appeals Council 90 day time limit	60 days to file	Medicare Appeals Council Expedited Decision 10 day time limit
	60 days to file		60 days to file		60 days to file		
Final Appeal Level	Federal District Court AIC => $1,350[B]		Federal District Court AIC => $1,350[B]		Federal District Court AIC => $1,350[B]		

AIC = Amount in Controversy
ALJ = Administrative Law Judge
Contractor = Fiscal Intermediary, Carrier or Medicare Administrative Contractor (MAC)
IRE = Independent Review Entity
MA-PD = Medicare Advantage Prescription Drug
MMA = Medicare Prescription Drug, Improvement & Modernization Act of 2003
PDP = Prescription Drug Plan
QIC = Qualified Independent Contractor

[A] Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.

[B] The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2012 AIC amounts.

[C] A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, or the enrollee's physician. The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins when the plan sponsor receives the physician's supporting statement.

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	▪ Eligible for Medicare Part A ▪ Income not exceeding 100% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012: $6,940 individual/$10,410 married couple living together with no other dependents ▪ Effective the first of the month after QMB eligibility is determined ▪ Eligibility cannot be retroactive	Part A and Part B premiums, deductibles, co-insurance, and copays
Specified Low-income Medicare Beneficiary (SLMB)	▪ Eligible for Medicare Part A ▪ Income at least 100%, but not exceeding 120% of FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Individual (QI)	▪ Eligible for Medicare Part A ▪ Income at least 120% but does not exceed 135% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 for an individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium
Qualified Disabled and Working Individual (QDWI)	▪ Entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA) ▪ Income not higher than 200% FPL ▪ Resources not exceeding twice maximum for SSI – For 2012: $4,000 for an individual/$6,000 married couple living together with no other dependents ▪ Cannot be otherwise eligible for Medicaid	Part A premium

E-mail: NMTP@cms.hhs.gov
Website:cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244