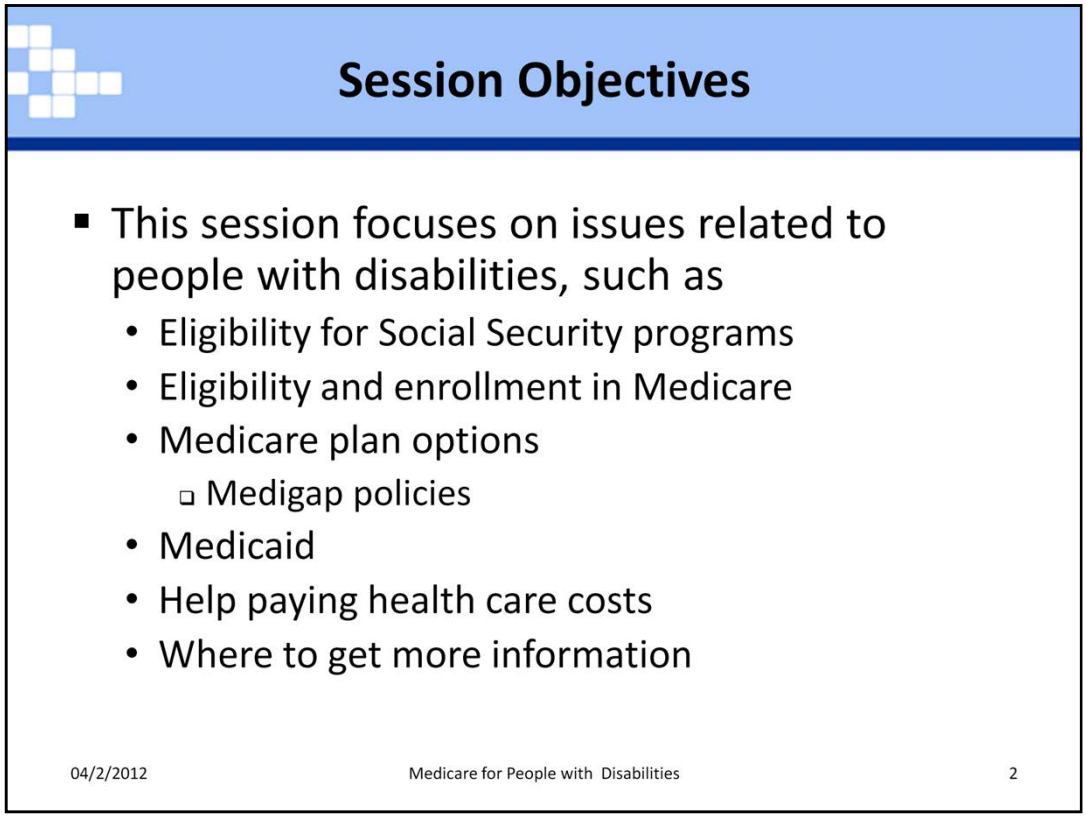
This module explains Medicare and other programs for people with disabilities.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, Pre-existing Condition Insurance Plans (PCIP), and the Children's Health Insurance Program (CHIP). 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.

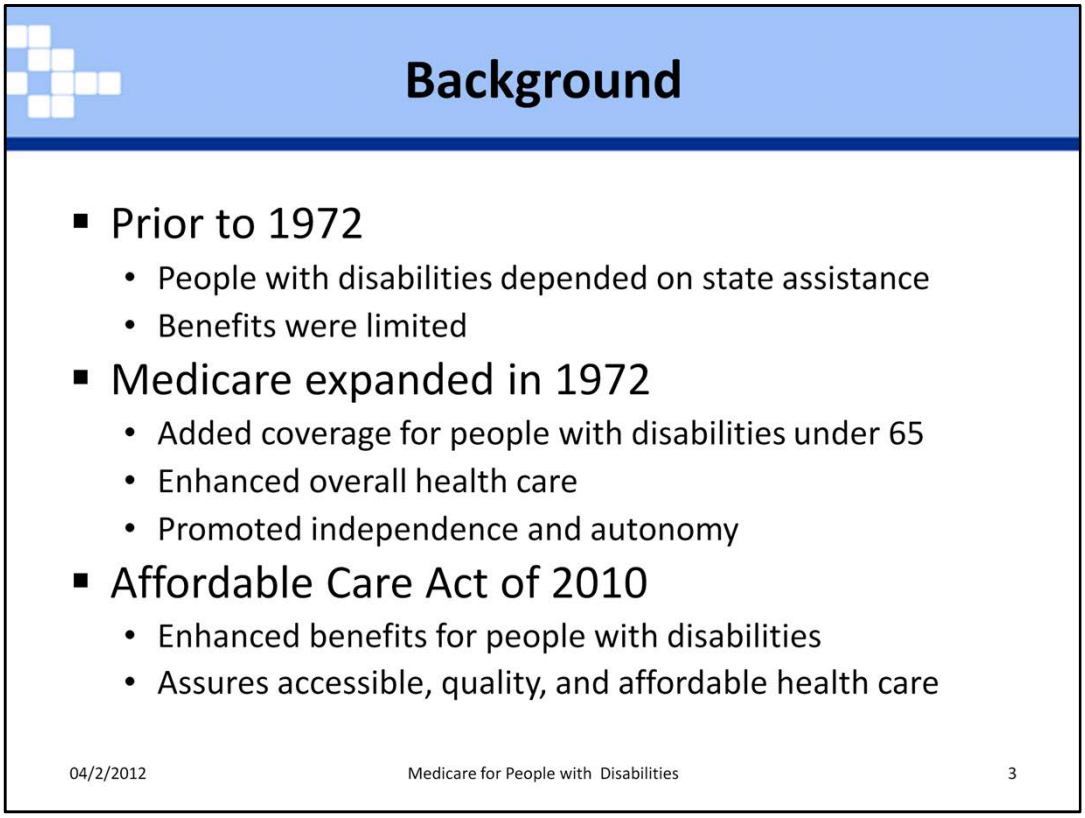
To check for an updated version of this training module, visit http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html

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 focuses on issues related to people with disabilities, such as

- Eligibility for Social Security programs
- Eligibility and enrollment in Medicare
- Medicare plan options
  - Medigap policies
- Medicaid
- Help paying health care costs
- Where to get more information

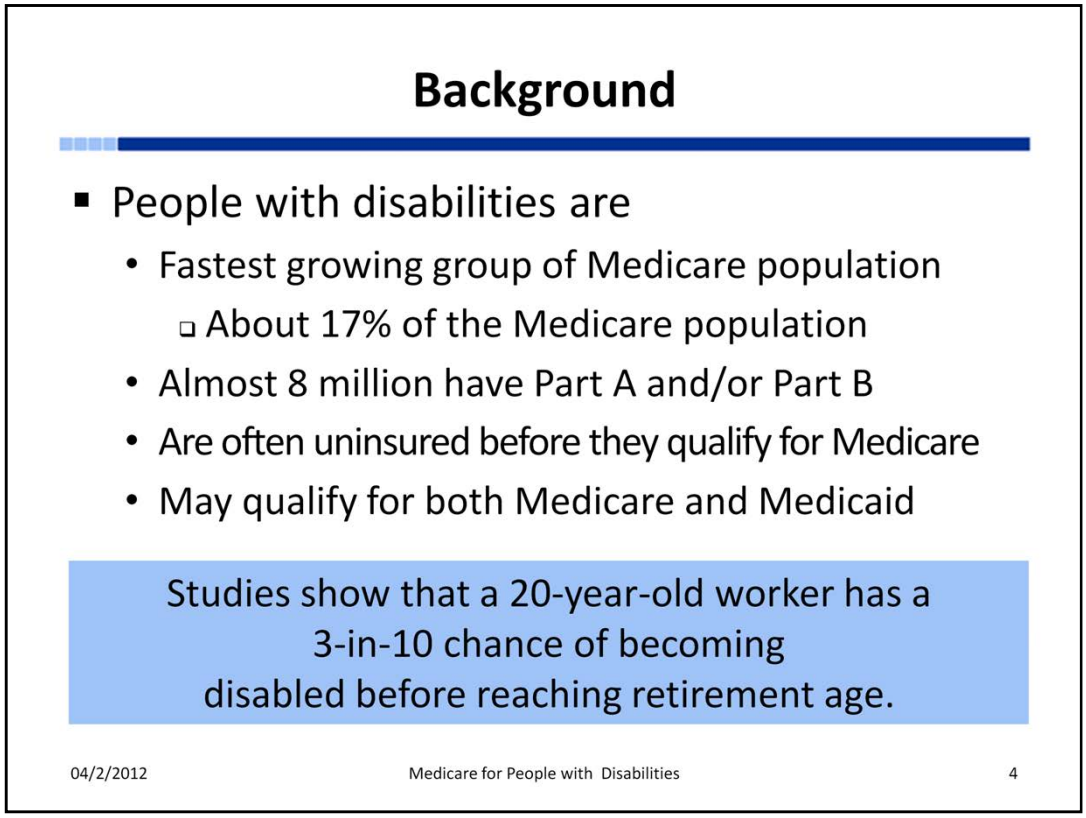


When Medicare was expanded in 1972 to cover people under age 65 with disabilities, it played a key role in promoting independence and autonomy and in enhancing health care for the disability population which had traditionally been underserved.

Prior to the Medicare expansion, people with disabilities were mostly dependent on state or charity programs.

Recent legislative enhancements to both Medicare and Medicaid have provided an even broader set of benefits, such as free preventive services, more affordable durable medical equipment (DME) and increased long-term care and community living options.

The Affordable Care Act (ACA) of 2010 enhanced benefits for people with disabilities, and assures accessible, quality, and affordable health care.



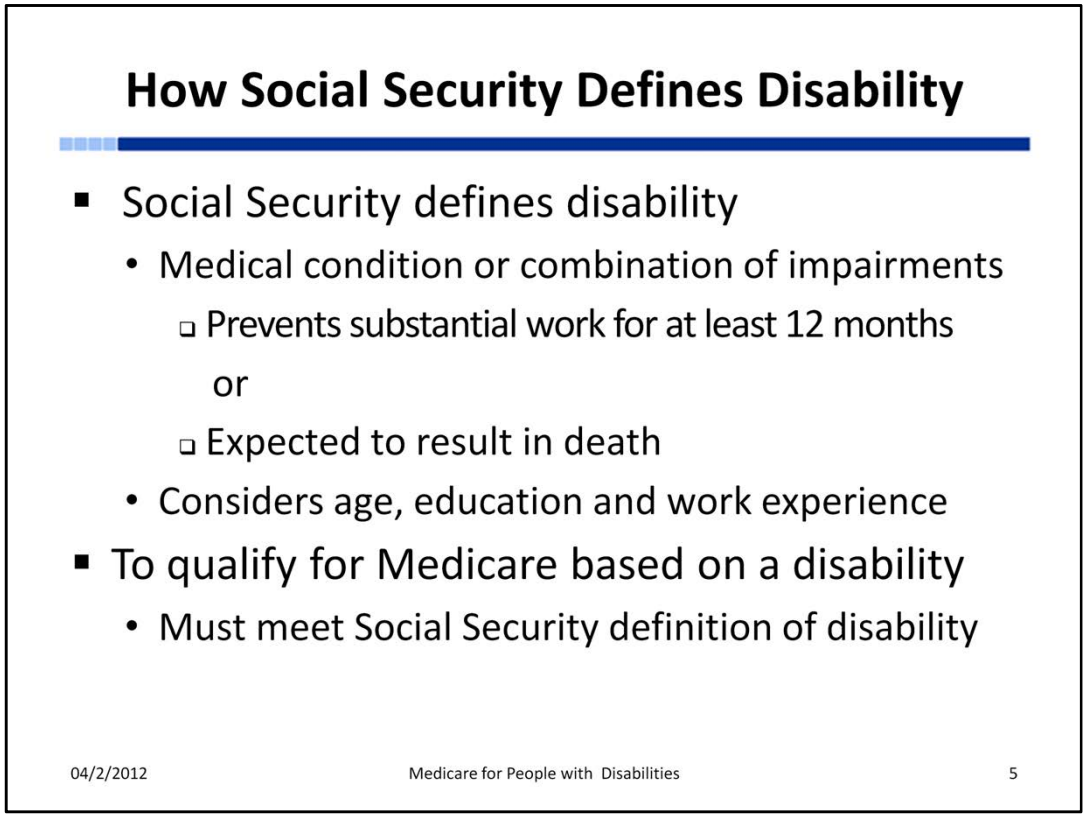
People with disabilities

- Represent the fastest growing group of the Medicare-entitled population, consisting of mostly younger beneficiaries (65 & under) who have very little knowledge of the Medicare program
- Constitute about 17% of the Medicare population
- Are often uninsured before they qualify for Medicare
- May qualify for both Medicare and Medicaid
- Studies show that a 20-year-old worker has a 3-in-10 chance of becoming disabled before reaching retirement age (source SSA)

Of the people who are enrolled in Medicare based on a disability

- 7,600,524 have Part A and/or Part B
- 760,915 have Part A Only
- 6,838,950 have Part A and Part B

For more information visit http://www.cms.gov/MedicareEnrpts/Downloads/09Disabled.pdf



To qualify for Medicare based on a disability an individual must meet the Social Security definition of disability.

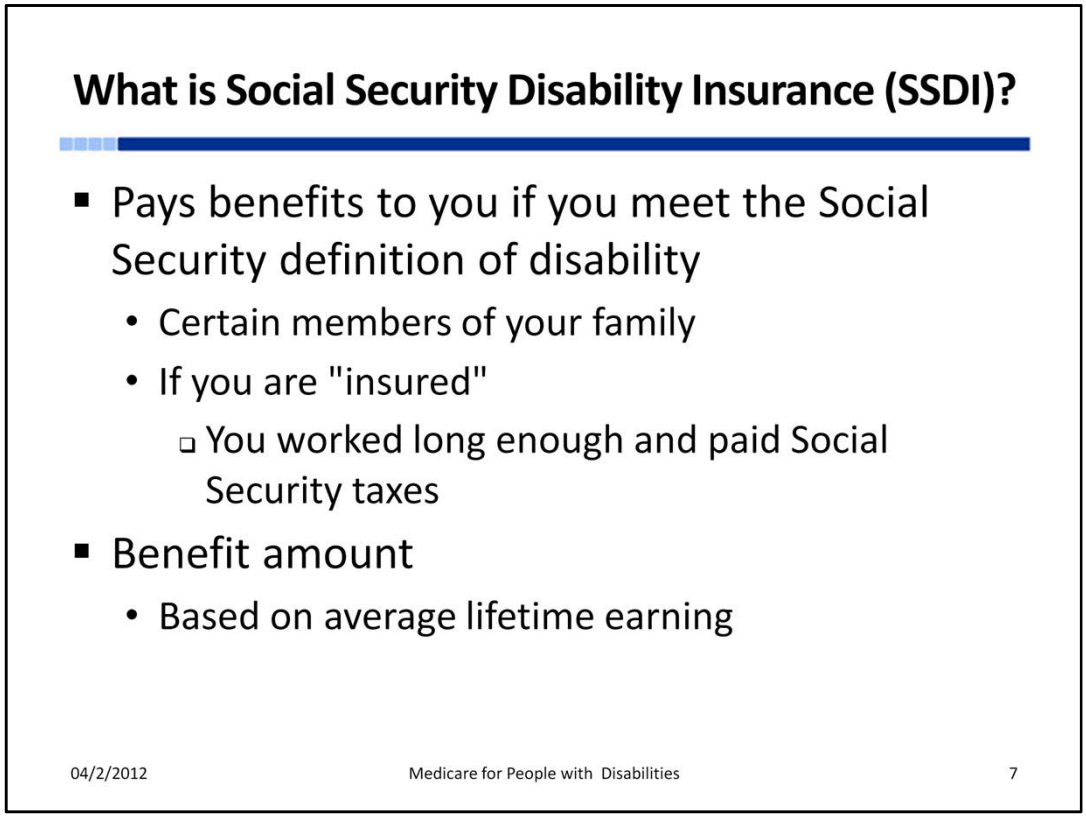
Social Security defines a disability as

- Medical condition or combination of impairments
- Preventing substantial gainful activity (SGA) for at least 12 months, or expected to result in death
  - SGA of $1,010 per month gross earnings ($1,690 per month if blind)
  - The determination also considers age, education and work experience.

Social Security for People with Disabilities

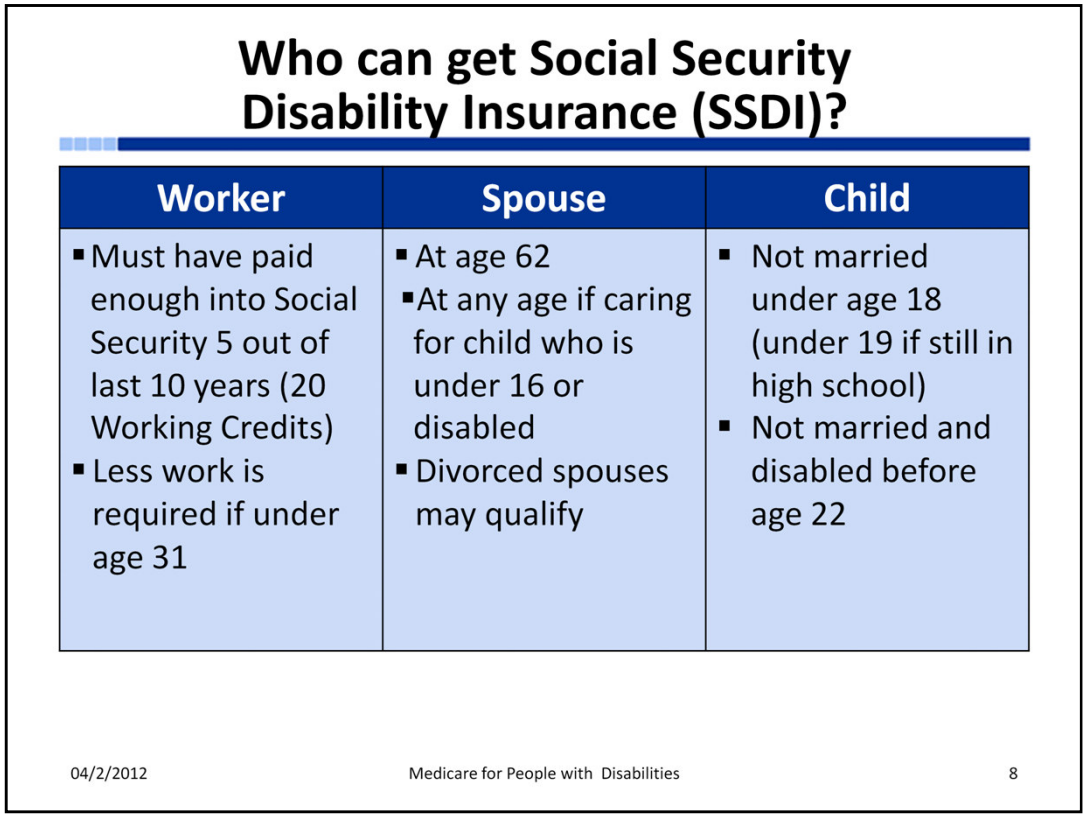
- Federal programs providing cash benefits
  - For people with disabilities
    - Social Security Disability Insurance (SSDI)
    - Supplemental Security Income (SSI)
- Administered by Social Security

- Federal programs providing cash benefits to persons with disabilities
- Administered by Social Security
  - Social Security Disability Insurance (SSDI)
  - Supplemental Security Insurance (SSI)



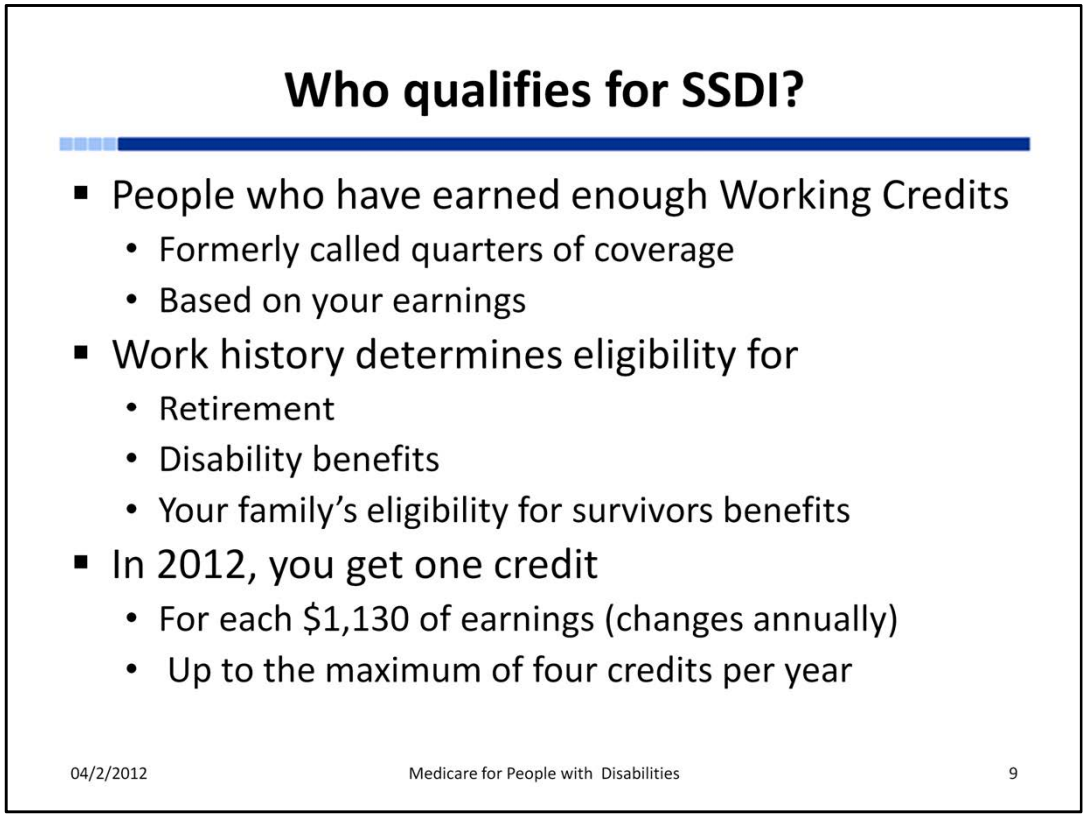
Social Security Disability Insurance (SSDI)

- Pays benefits to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes
- Benefit amount is based on average lifetime earning



Who can get Social Security Disability Insurance (SSDI)?

- The worker
  - Must have paid enough into Social Security 5 out of the last 10 years
  - Needs less work if under age 31
- A spouse
  - At age 62
  - At any age if caring for child who is under 16 or disabled
  - Divorced spouses may qualify if
    - Married to the worker for at least 10 years
    - Unmarried
    - Not entitled to a higher Social Security benefit on his or her own record (20 CFR §404.336)
- A child
  - Not married under age 18 (under 19 if still in high school)
  - Not married and disabled before age 22



Social Security Working Credits (formerly called quarters of coverage) are based on your earnings.

Work history determines eligibility for

- Retirement
- Disability benefits
- Your family's eligibility for survivors benefits

In 2012, you get one credit

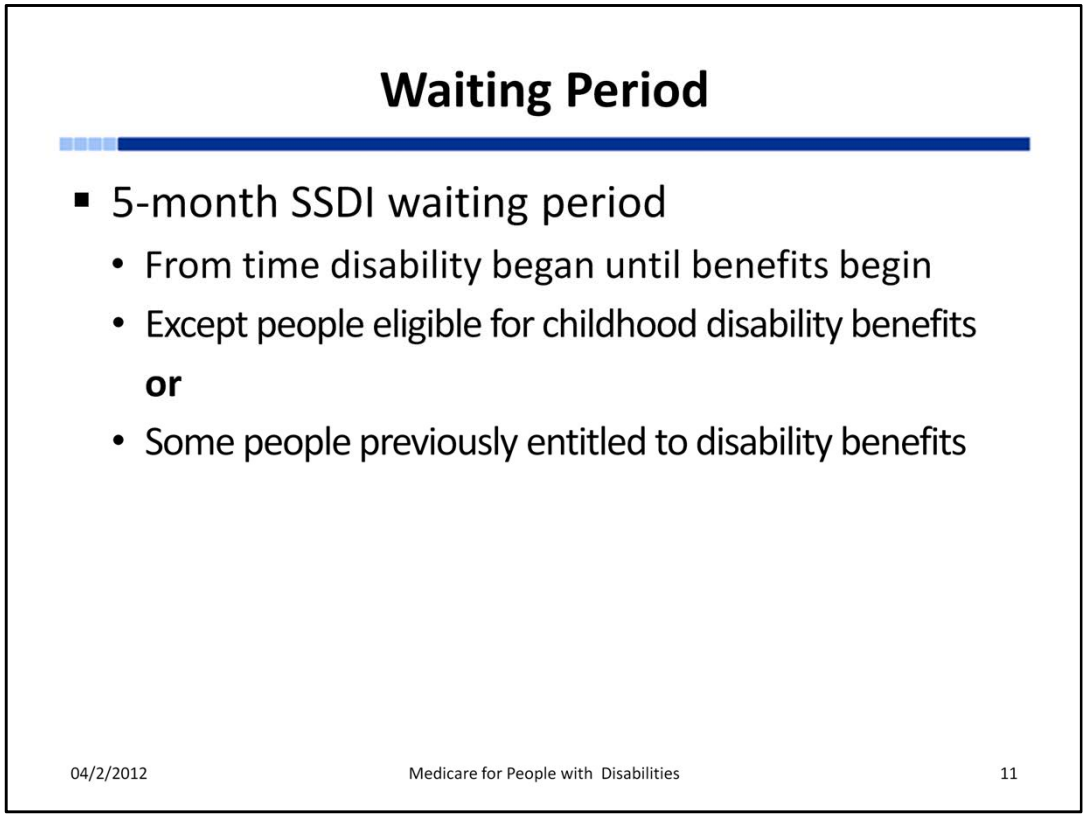
- For each $1,130 of earnings (changes annually)
- Up to the maximum of four credits per year

Work Credits Required for SSDI

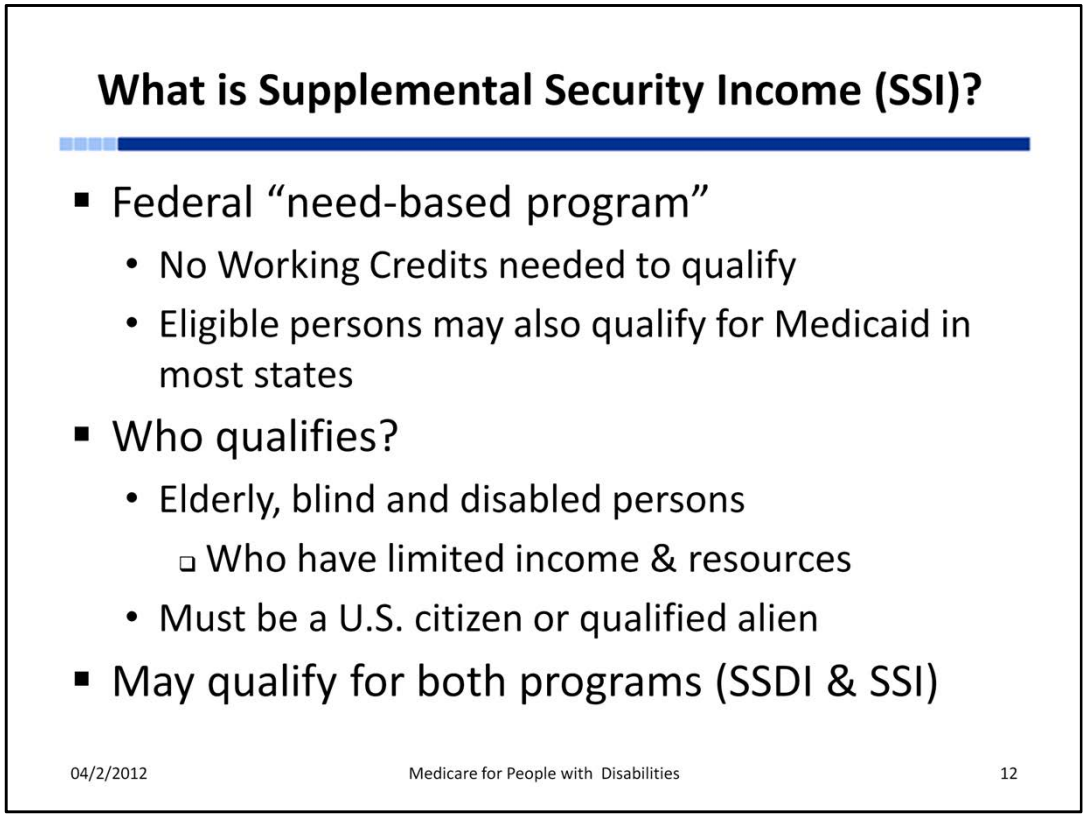
Age when disabled	Credits required
Before 24	Generally 1 ½ years of work (6 credits) in 3 years before you became disabled
24 – 30	Generally need credits for half of the time between age 21 and age you became disabled
31 or older	Generally need at least 20 credits in the 10 years immediately before you became disabled

Work credits required for SSDI vary by age:

- If you became disabled before age 24, you generally need 1½ years of work (6 credits) in the 3 years before you became disabled.
- If you became disabled between the ages of 24 and 30, you generally need credits for half of the time between age 21 and the age you became disabled.
- If you were 31 or older when you became disabled, you generally need at least 20 credits in the 10 years immediately before you became disabled.



In most cases, there is a waiting period of five full calendar months from the time your disability began until benefits can begin. If your application is approved, your first Social Security benefit will be paid starting with the sixth full month after the date your disability began. The five-month waiting period for cash benefits does not apply to people who get childhood disability benefits or to some people who were previously entitled to disability benefits.



Supplemental Security Insurance (SSI) is a Federal 'need-based program':

- No working quarters are needed to qualify
- Eligible persons may also qualify for Medicaid in most states

To qualify, you must be elderly, blind or disabled and have limited income and resources.

You must be a U.S. citizen or a specific kind of qualified, lawfully present alien who was lawfully residing in the US on 8/22/96.

People may qualify for both SSDI and SSI programs.

You can shorten the application process by taking certain documents and information with you when you apply.

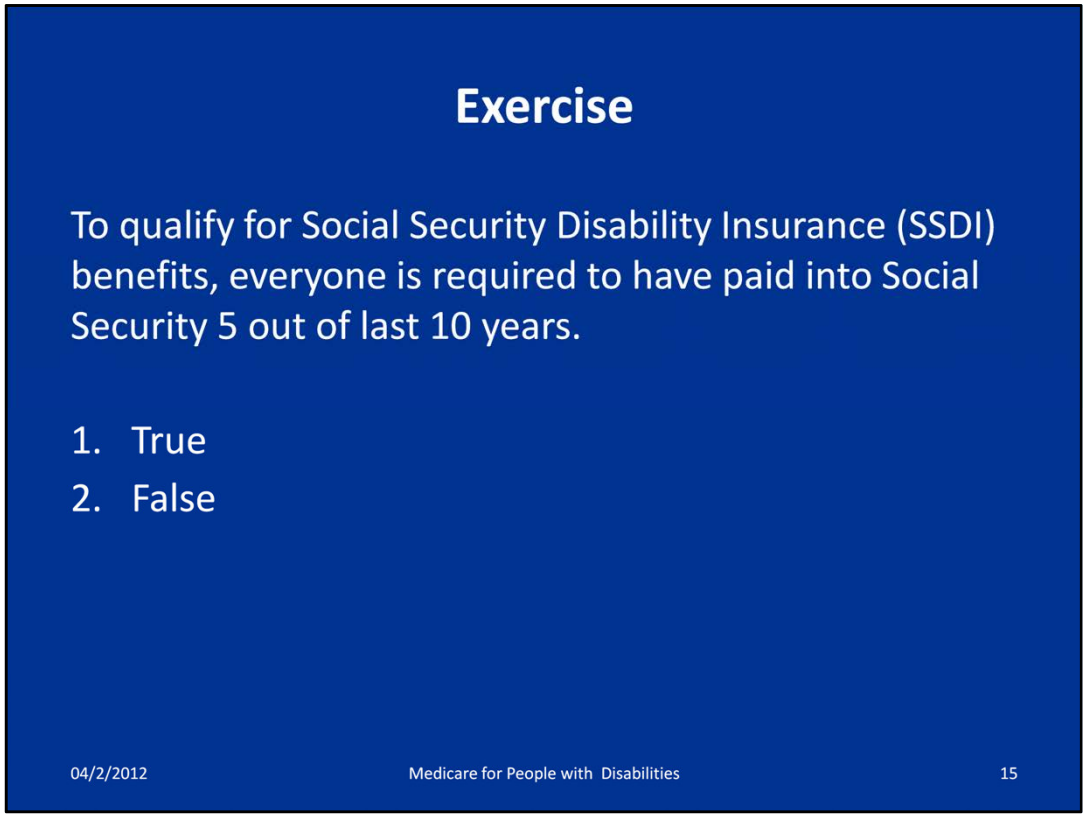
- These include
  - Social Security number and proof of age for you and your dependents, and dates of any prior marriages if your spouse is applying
  - Names, addresses, phone numbers, fax numbers, and dates of treatment for doctors, hospitals, clinics, and institutions that have treated you
  - Names of all medications you are taking
  - If available, your medical records showing exams, treatments, and laboratory and other test results
  - A summary of where you have worked and the kind of work you did, including your most recent W-2 form (Wage and Tax Statement), or if self-employed your Federal tax return

IMPORTANT: You must, upon request provide original documents or copies certified by the issuing office. Social Security will make photocopies and return the original documents. **NOTE**: Neither the original Social Security card nor certified copies of medical records are needed.

You should not wait to apply, even if you don't have all of the information. The Social Security office will help you get the information you need. (If you have railroad employment, call the Railroad Retirement Board (RRB) at 1-877-772-5772 or your local RRB office).

To apply for Disability Benefits, you apply with Social Security

- Apply online http://www.socialsecurity.gov/applyfordisability/
- Apply in person
  - Call 1-800-772-1213 (TTY 1-800-325-0778) between 7 a.m. and 7 p.m., Monday through Friday to make an appointment
- For SSDI – Both medical and non-medical portions can be completed online.
- For SSI – Only the medical portion can be completed online. The non-medical portion must be completed in-person or by phone.
- Set up a telephone or in-office appointment and you will receive a Disability Starter Kit to help you prepare.
- The average processing time for a disability claim is four months.



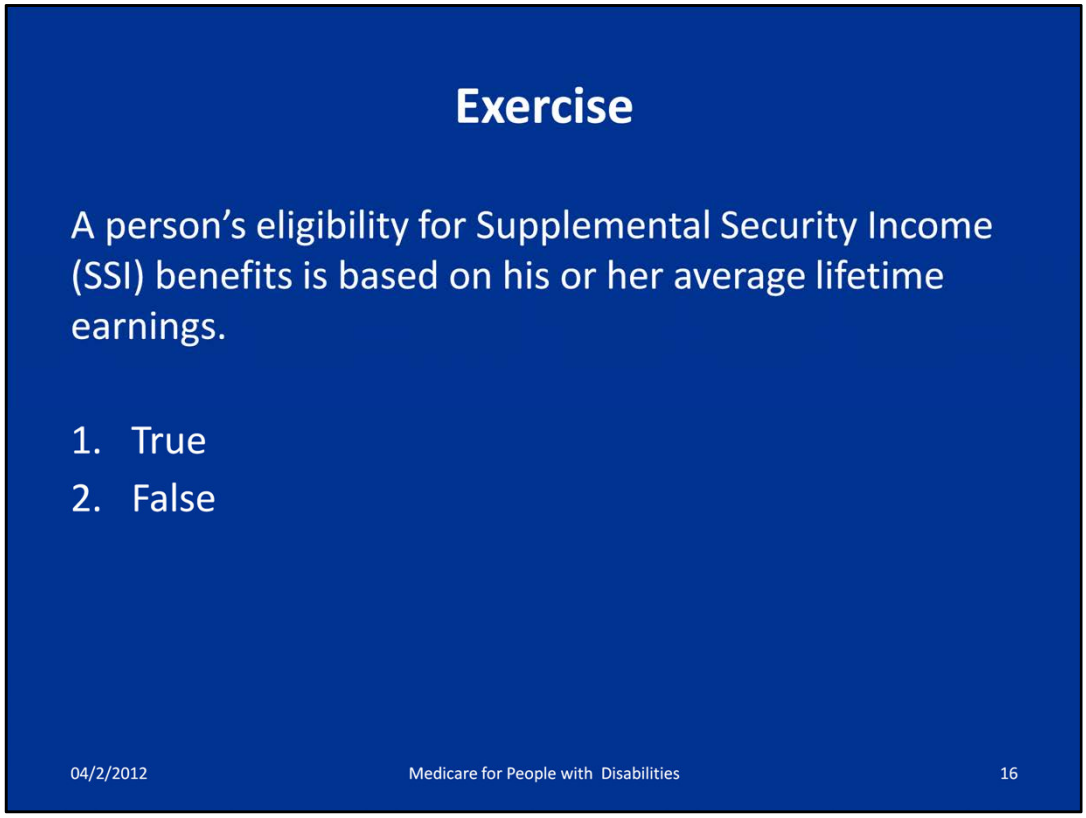
Exercise

To qualify for Social Security Disability Insurance (SSDI) benefits, everyone is required to have paid into Social Security 5 out of last 10 years.

1. True
2. False

Answer: 2. False

- If you became disabled before age 24, you generally need 1½ years of work (6 credits) in the 3 years before you became disabled.
- If you became disabled between the ages of 24 and 30, you generally need credits for half of the time between age 21 and the age you became disabled.
- If you were 31 or older when you became disabled, you generally need at least 20 credits in the 10 years immediately before you became disabled.

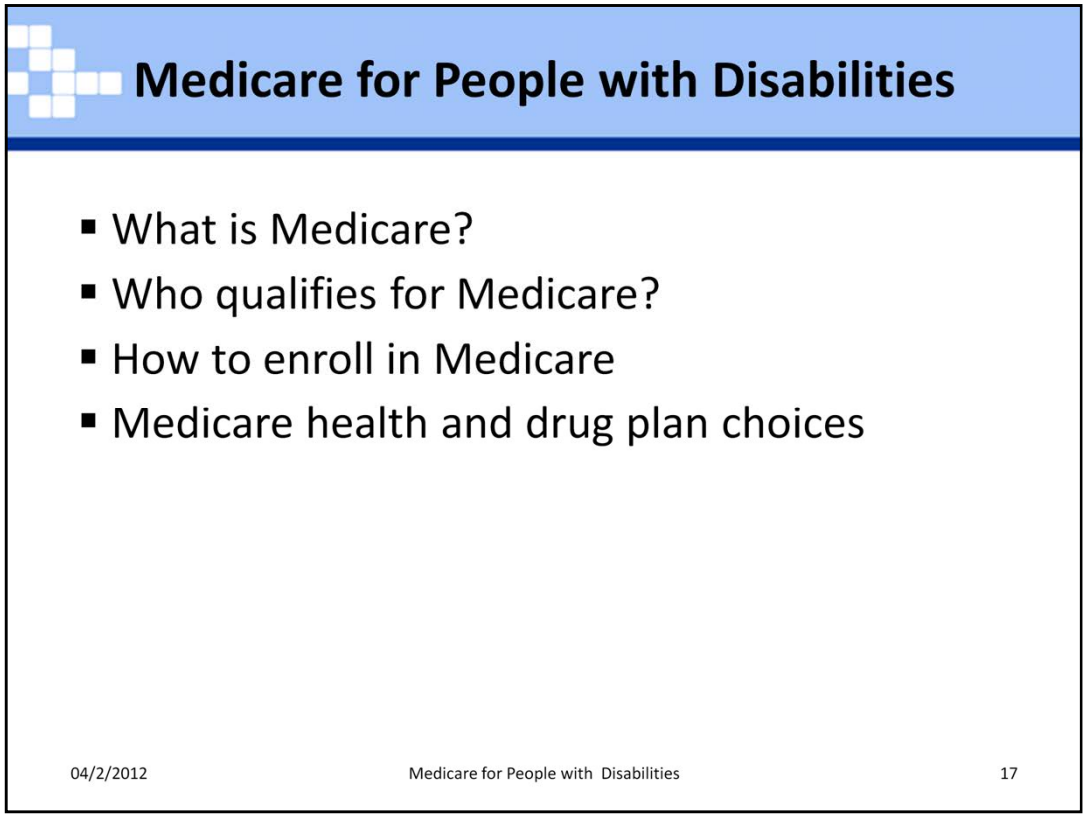


Exercise

A person's eligibility for Supplemental Security Income (SSI) benefits is based on his or her average lifetime earnings.

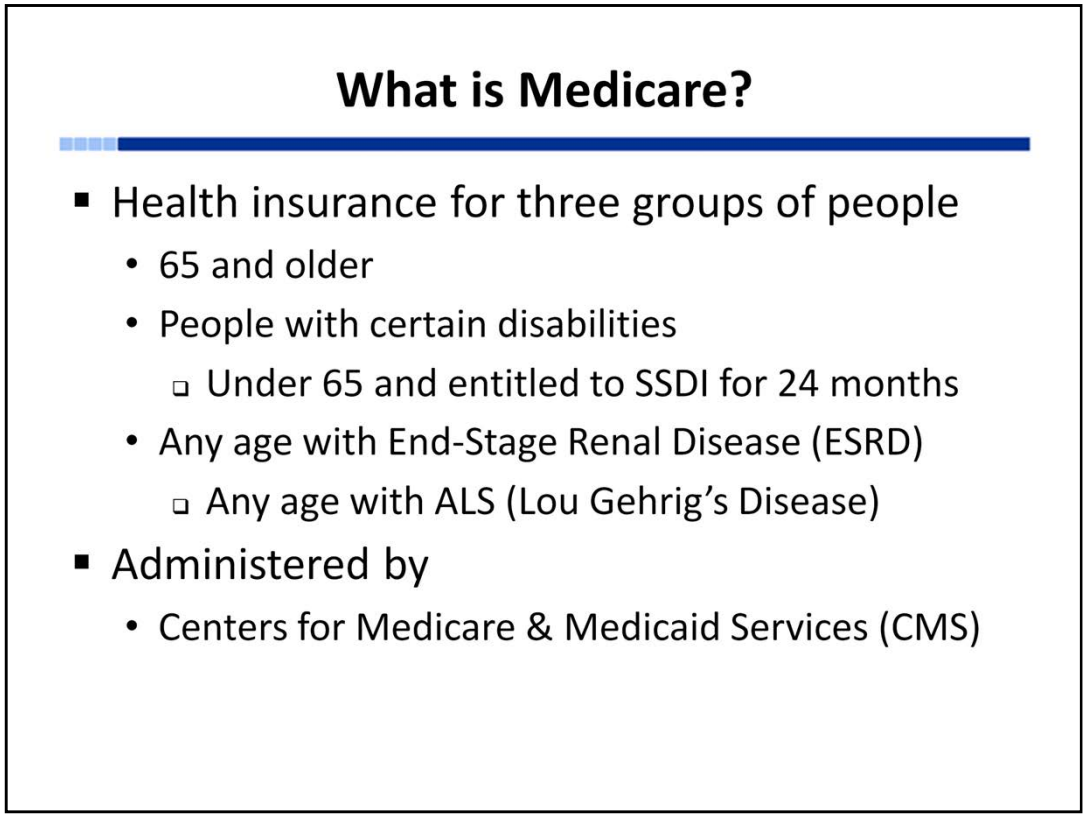
1. True
2. False

Answer. 2. False.
Supplemental Security Income is a need-based program and is not based on a person's average lifetime earnings.



Medicare for People with Disabilities

- What is Medicare?
- Who qualifies for Medicare?
- How to enroll in Medicare
- Medicare health and drug plan choices

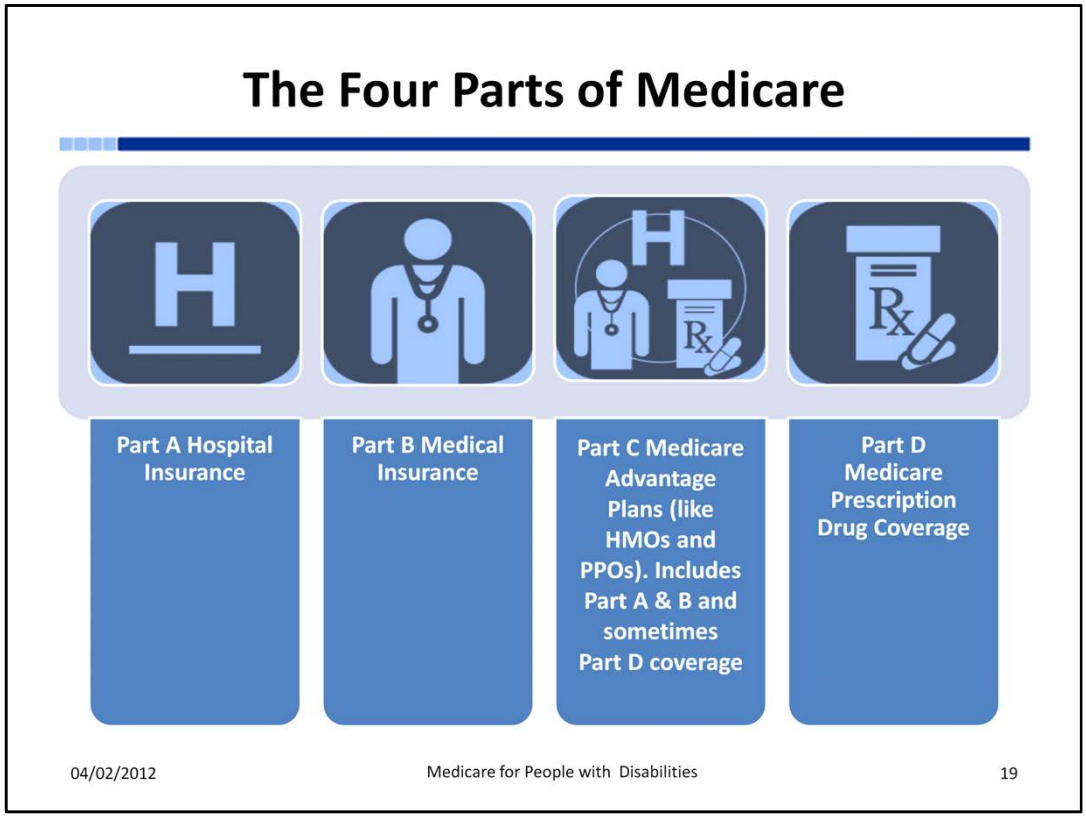


President Lyndon Johnson signed the Medicare and Medicaid programs into law July 30, 1965. Medicaid became effective January 1, 1966, and Medicare became effective July 1, 1966. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS).

Medicare is the nation's largest health insurance program, currently covering about 48 million Americans.

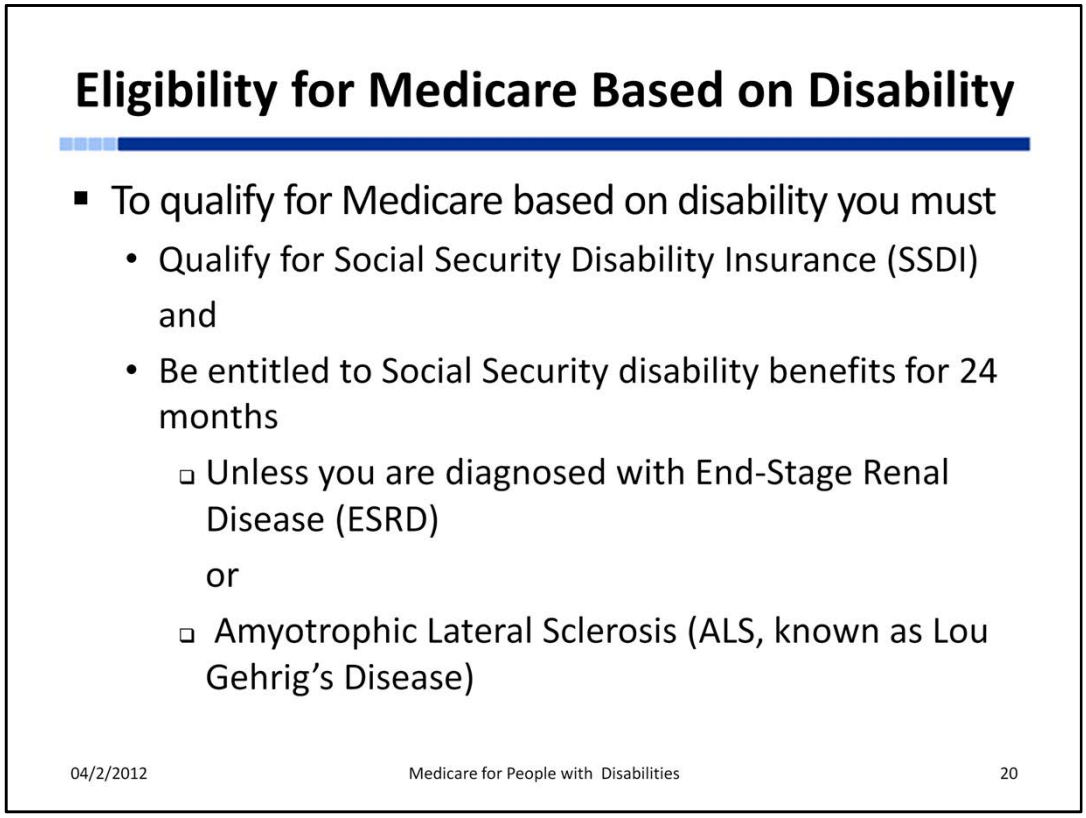
Medicare is health insurance for three groups of people.

- Those who are age 65 and older.
- People under age 65 with certain disabilities who are entitled to Social Security disability insurance (SSDI) or Railroad Retirement benefits for 24 months. The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, 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).



Medicare has four parts:

1. Part A is Hospital Insurance
2. Part B is Medical Insurance
3. Part C is Medicare Advantage which are plans like HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations). Part C includes Part A and Part B coverage and sometimes includes Part D.
4. Part D is Medicare Prescription Drug Coverage



The 1972 Social Security Amendments expanded Medicare to cover two additional groups:

- People under age 65 with a disability who have been entitled to Social Security benefits for 24 months.
- People with End-Stage Renal Disease (ESRD) who meet special Social Security earnings requirements.
  - Remember, people with ESRD do not need to be entitled to Social Security benefits to qualify for Medicare. However, if they are also entitled to disability benefits, they may qualify under both programs.
  - The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, 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.

Automatic Enrollment

- Initial Enrollment Period Package (IEP) Mailed
  - 3 months before 25th month of disability benefits
  - Those with ALS - about 4 weeks after Medicare entitlement
  - Decide whether to keep Part B
  - Decide whether to enroll in Part D
- Call Social Security if Medicare card doesn't arrive

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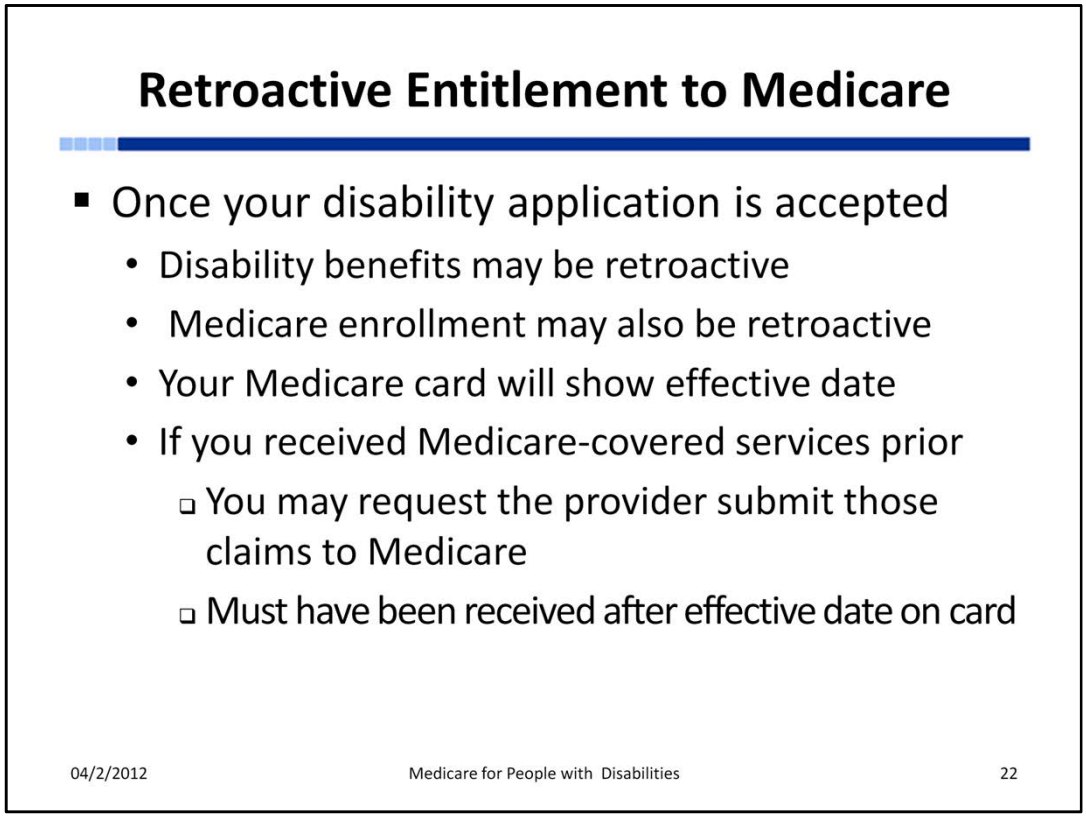
If you are already receiving Social Security benefits (for example, getting Social Security disability benefits) you will be automatically enrolled in Medicare Part A and Part B without an additional application. You will receive your Initial Enrollment Period package (IEP), which includes your Medicare card and other information about 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits). **NOTE**: If you live in Puerto Rico or a foreign country and you get benefits from Social Security or the RRB, you will be automatically enrolled in Part A. If you want Part B you will need to sign up for it. Your IEP package will look slightly different.

When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care. The Medicare card shows the Medicare coverage (Part A hospital coverage and/or Part B medical coverage) and the date the coverage starts.

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 and how you are related to the person. 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 (these letters and numbers don't indicate having Medicare Part A, B, C or D).

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. Call Social Security at 1-800-772-1213 if your card does not arrive.



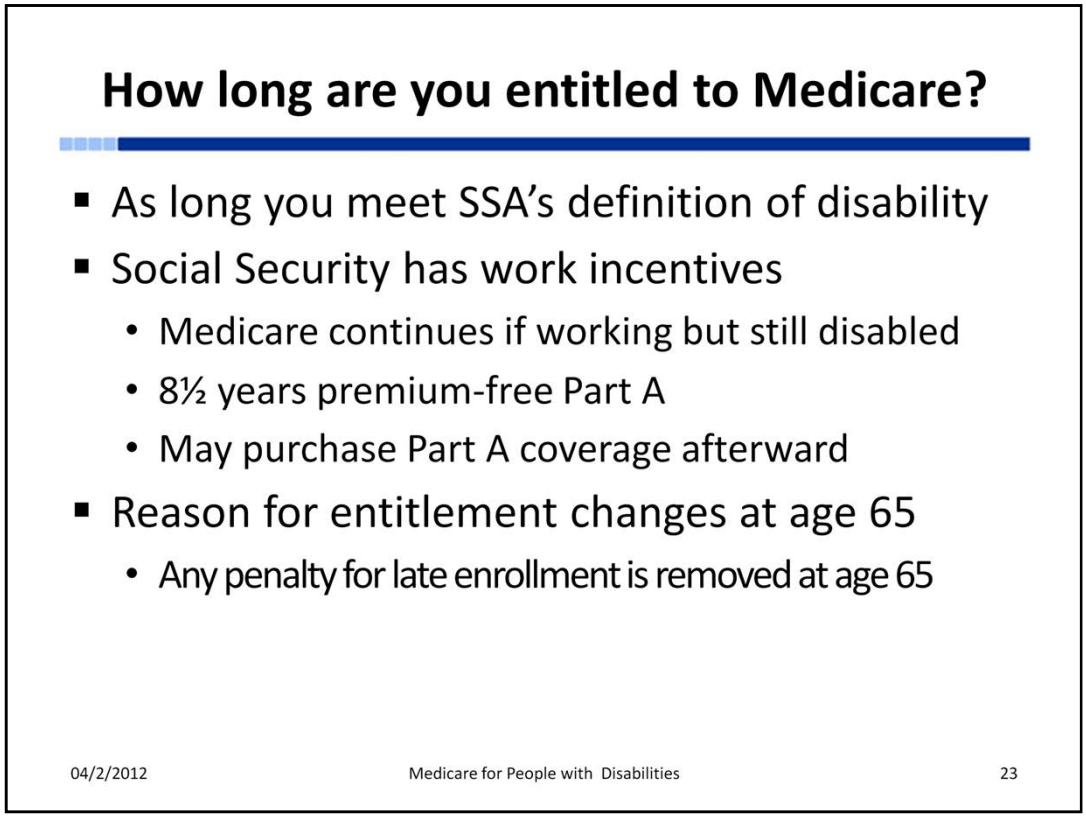
There are times when a disability determination will be made on appeal (giving an earlier date of onset and entitlement to Social Security Disability benefits); or, the application isn't processed timely, resulting in retroactive Medicare Part A entitlement. Nevertheless, the Part A entitlement date will always be the 25th month of disability benefit entitlement. The Part B entitlement date is the 25th month of disability benefit entitlement if, at the time the disability application is processed, the beneficiary owes less than six months of retroactive Part B premiums. If six or more months of premiums are owed, Medicare Part B is effective the month the disability application is processed. You will get the following information:

- The effective date of Part A coverage (the 25th month of disability benefit entitlement).
- The effective date of Part B coverage (the month of processing), and the option to elect Part B coverage effective with the 25th month of disability benefit entitlement.

To exercise this option, you must submit a written request for retroactive Part B entitlement and agree to pay all retroactive premiums due. If retroactive Part B coverage is elected, you are sent a second letter stating that you have the retroactive Part B coverage. The letter also provides instructions for the provider to file Part B claims outside the timely filing limit.

Deemed Date of Enrollment

Because of the uncertainty involved in determining the Initial Enrollment Period for an individual filing for re-entitlement to disability benefits, the Part B enrollment request is deemed to have been filed in the third month of the IEP. This assures that the enrollee has the opportunity for coverage at the earliest possible date.



As long as you continue to meet the requirements for Social Security disability benefits, you continue to be entitled to Medicare. If Social Security determines that your disability benefits should be stopped because your condition has improved and you are no longer considered disabled under their guidelines, your Medicare will end with the month in which your disability benefits ends.

Social Security has work incentives to support people who are still medically disabled but try to work in spite of their disability. Continuation of Medicare coverage is one type of work incentive.

- You may have at least 8½ years of extended Medicare coverage if you return to work. Medicare continues even if Social Security determines that you can no longer receive cash benefits because you are earning above the substantial gainful activity level ($1,010 per month in 2012).
- If, after you have exhausted your 8 ½ years of extended Medicare coverage, you continue to work and continue to have a disabling physical or mental impairment, you may buy Part A, or Part A and Part B for as long as you continue to be disabled. We call this provision "Medicare for the Working Disabled."
- If you were paying an increased Part B premium during the time in which you were receiving premium-free Part A, but now are eligible for Part B because you are enrolling in Part A for the working disabled, your Part B premium will revert back to the standard rate.
- You will be billed for your Medicare premiums. If you are receiving Medicare benefits based on disability when you reach age 65, you have continuous coverage with no interruption. You will get Part A free, if you have been buying it. However, the reason for entitlement changes from disability to age. If you did not have Part B when you were disabled, you will automatically be enrolled in Part B when you turn age 65, but you will again be able to decide whether or not to keep it.

If you were paying an additional Part B premium (penalty for late enrollment) while you were disabled, the penalty will be removed when you reach age 65.

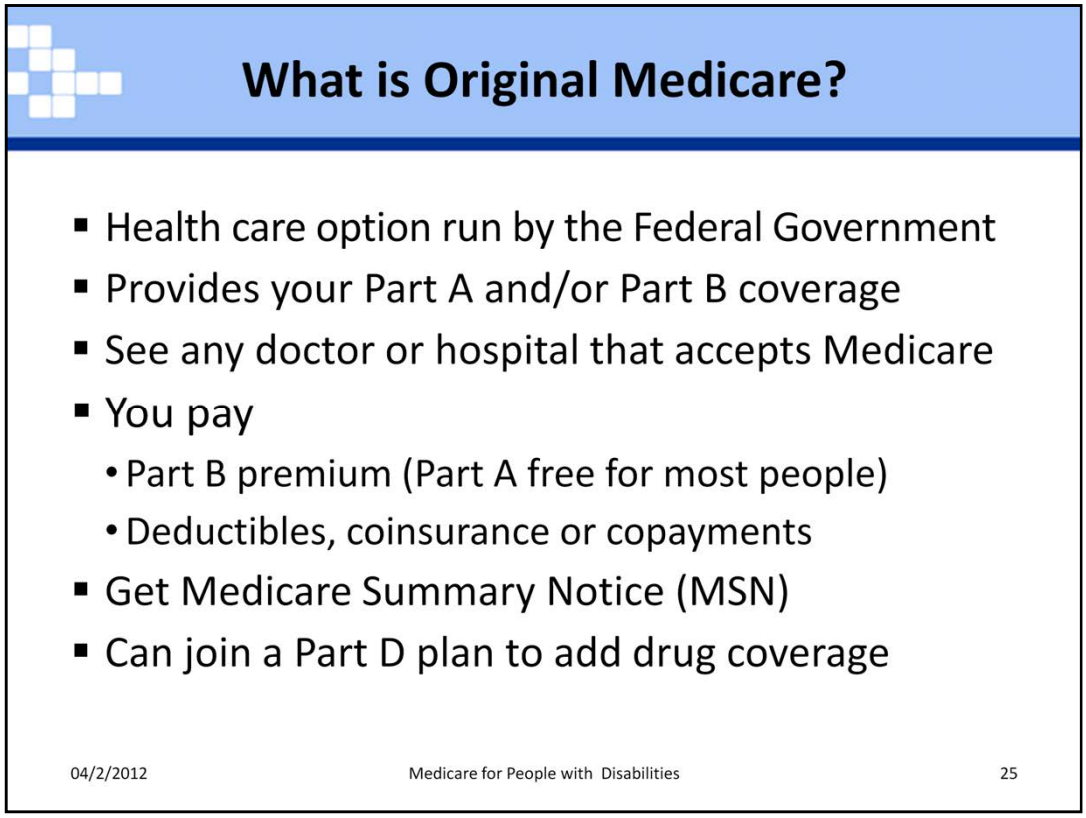
Plan Choices for People with a Disability

- All Medicare plans are available
  - Original Medicare
    - Medigap policy (supplements Original Medicare)
      - May not be available if under 65
  - Medicare Advantage Plans
  - Other Medicare plans
  - Medicare Prescription Drug Plans
- People with ESRD have limited choices

The same Medicare health plan choices are available to people with disabilities as those available to people age 65 and older, except for those with ESRD. You may choose Original Medicare or a Medicare Advantage Plan or other Medicare plan available in your area.

Medigap plans are available to those eligible based on disability, but may not be available to people with disabilities who are under age 65. Eligibility for those under 65 varies by state. Some states require Medigap plans to cover people with disabilities who are under age 65.

You may also join a Medicare drug plan. Enrolling in a Medicare drug plan is optional but can provide substantial savings for people with chronic medical conditions who may be taking multiple prescription drugs.



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. Most beneficiaries pay the 2012 premium of $99.90.

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 letter 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.

You can join a Medicare Prescription Drug Plan (Part D plan) to add drug coverage.

Medicare Part A – Hospital Insurance

- Covers
  - Inpatient hospital care
  - Skilled Nursing Facility care
  - Home health care
  - Hospice care
  - Blood

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Medicare Part A, hospital insurance helps pay for medically necessary services.

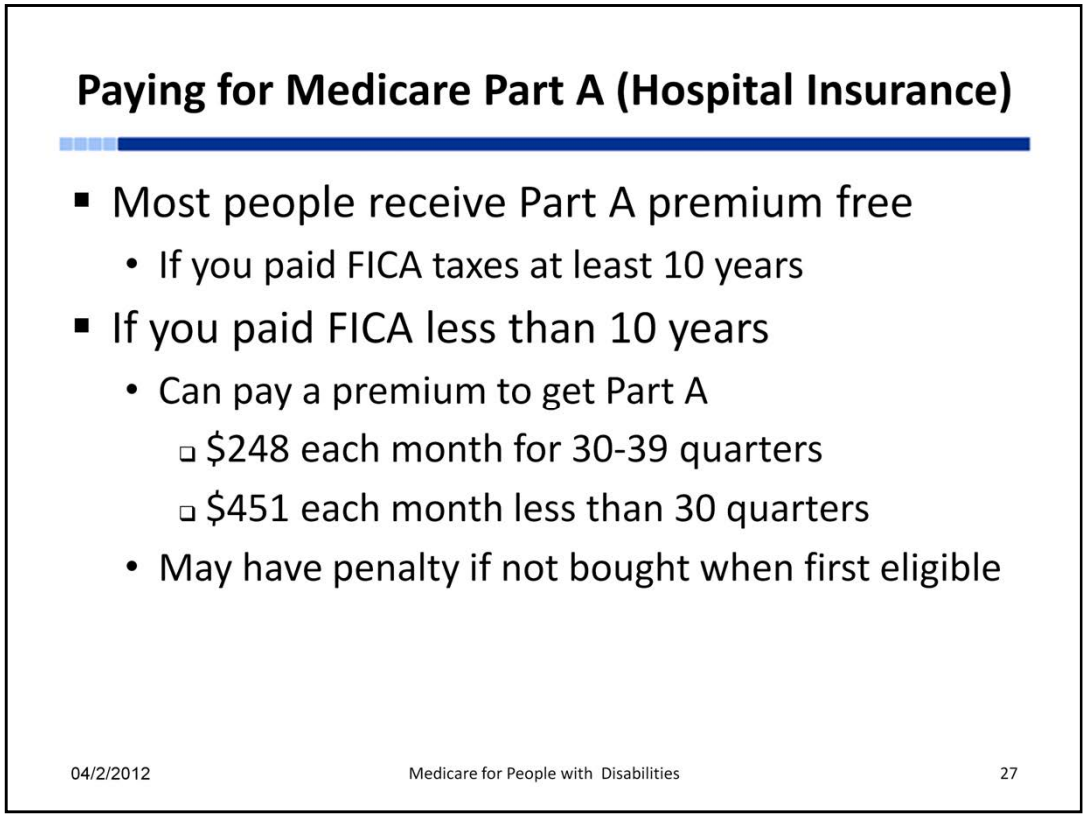
Hospital inpatient care - Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).

Skilled nursing facility (SNF) care (not custodial or long-term care) when certain conditions are met.

Home health care - 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 (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; as well 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 your Initial Enrollment Period 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.

Medicare Part B – Medical Insurance

- Covers
  - Doctor's visits
  - Outpatient hospital services
  - Clinical lab tests
  - Durable Medical Equipment (DME)
    - May require use of contract suppliers
    - In certain areas for certain supplies and equipment (See Competitive Bidding Program in Appendix A)
  - Preventive services

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Medicare Part B, medical insurance covers medically-necessary services and supplies. Certain requirements must be met.

Doctors' Services - Services that are medically necessary.

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.

Durable Medical Equipment, like wheelchairs, walkers, canes, etc. See Appendix A for information on the Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Program.

Preventive Services, like exams, lab tests, screening and shots to help prevent, find, or manage a medical problem. Preventive services may find health problems early when treatment works best.

Monthly Part B Premium

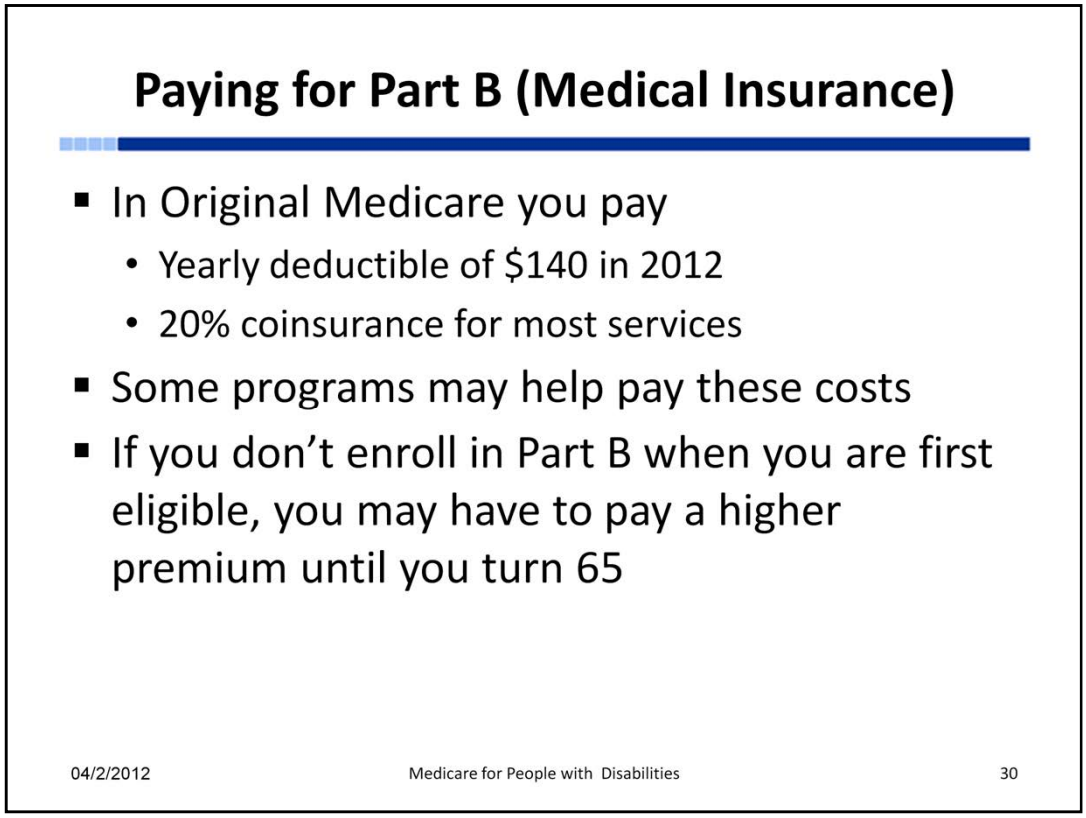
If your Yearly Income in 2010 was		You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or below	$170,000 or below	$99.90
$85,001–$107,000	$170,001–$214,000	$139.90
$107,001–$160,000	$214,001–$320,000	$199.80
$160,001–$214,000	$320,001–$428,000	$259.70
above $214,000	above $428,000	$319.70

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

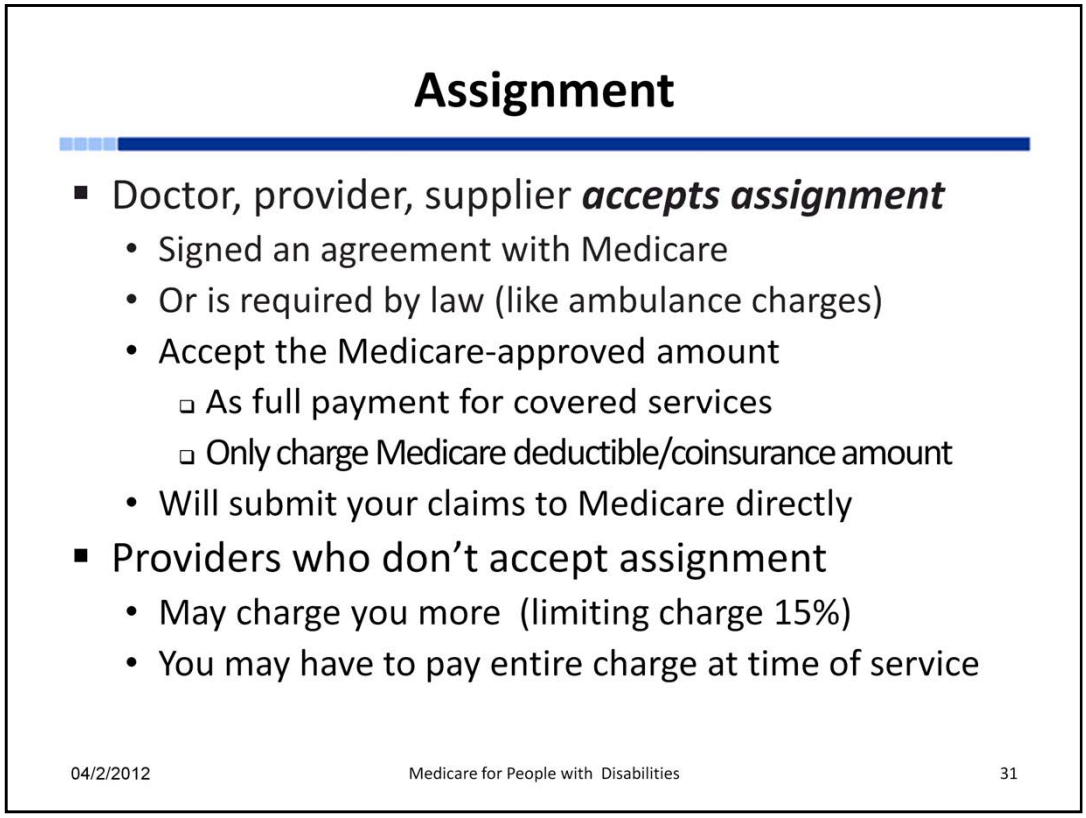


If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. The 2012 Part B deductible is $140 per year. This means that you must pay the first $140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

If you don't enroll in Part B when you are first eligible, you may have to pay a higher premium until you turn 65.



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, you may have to file your own claim for Medicare to pay. Doctors and other providers generally have to submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service.

To find doctors and suppliers who accept assignment and participate in Medicare, http://www.medicare.gov/find-a-doctor/provider-search.aspx or call 1-800-MEDICARE.

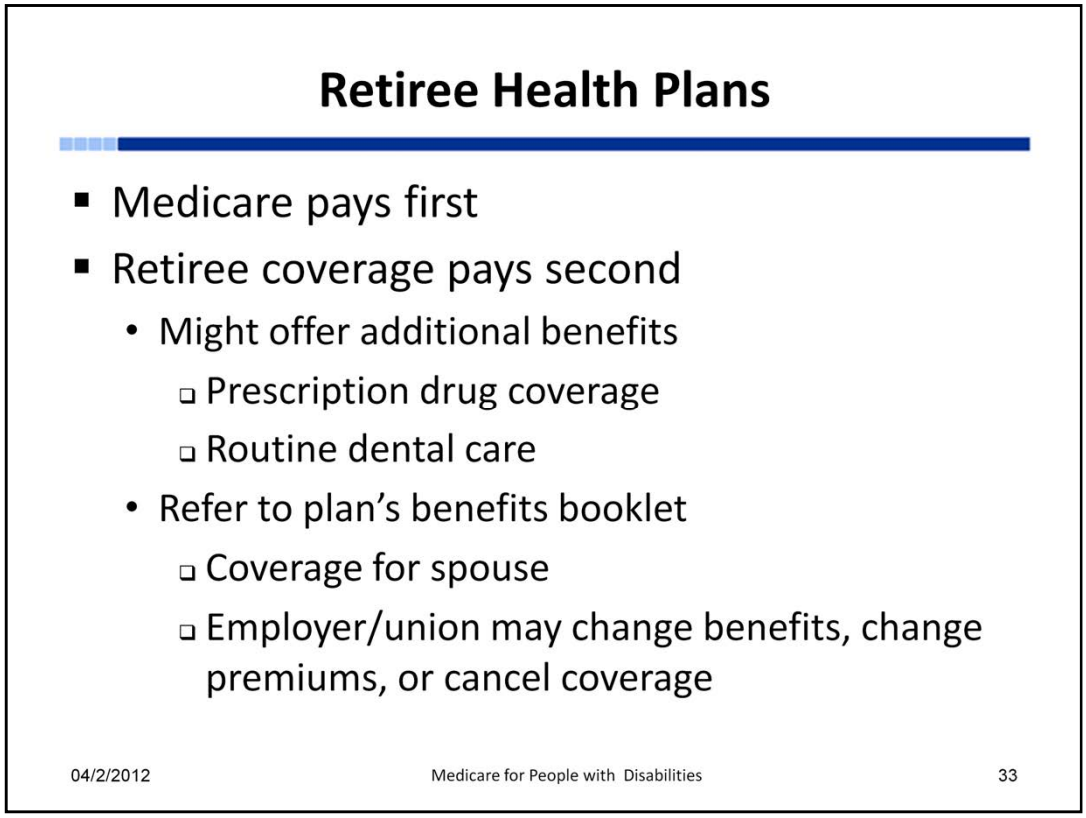
Large Employee Group Health Plan (LGHP) and Medicare Due to Disability

- Medicare based on disability **and**
  - Working and covered by large EGHP or
  - Covered by LGHP of working spouse
    - Or other family member
- Medicare is secondary payer
  - If employer has 100 or more employees or
  - Self-employed, if covered by LGHP of employer with 100 or more employees

Medicare is the secondary payer for people who are under age 65 and entitled to Medicare because of a disability if they are covered by a large employer group health plan (EGHP) through current employment, either their own or that of a family member. In this instance, the employer must have 100 or more employees.

Medicare is also secondary payer for people with Medicare who are under 65 and disabled if they are self-employed, or a family member is self-employed, and they are covered by an LGHP of an employer that has 100 or more employees.

If any one employer within a multiple employer health plan has 100 or more employees, Medicare is secondary for all. This includes individuals associated with employers within the group that have less than 100 employees.



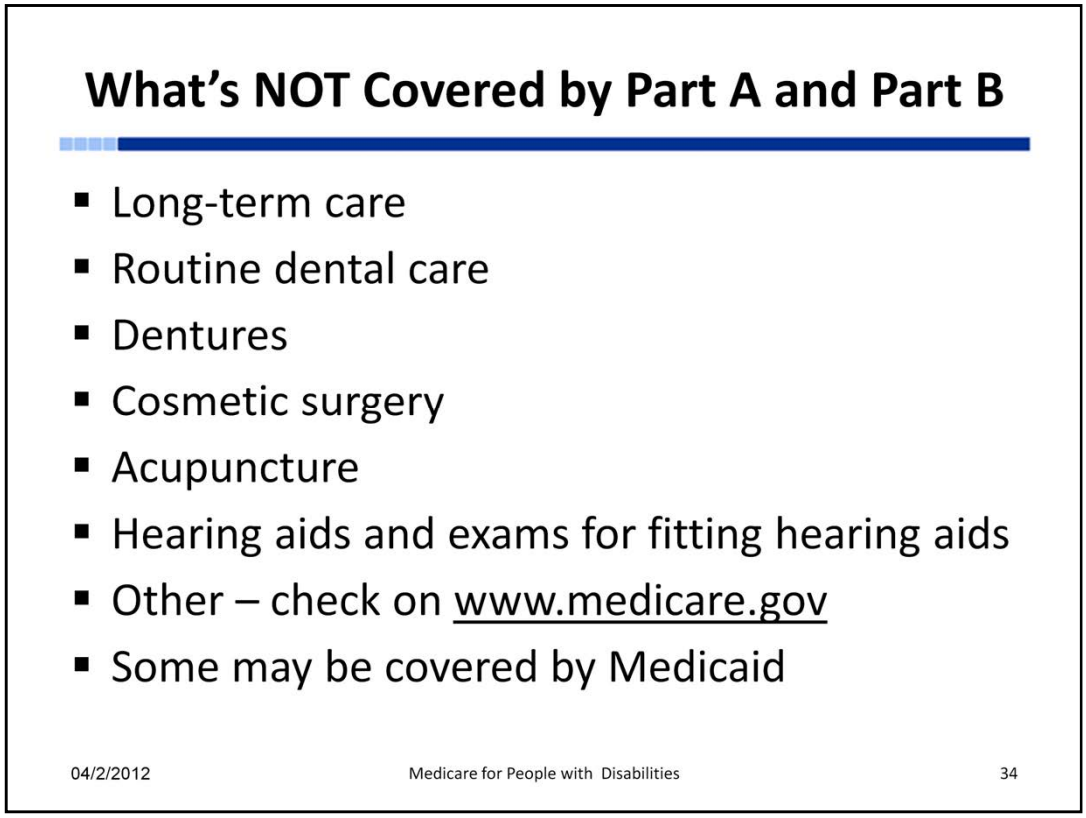
Generally, Medicare will pay first for health insurance claims, and the retiree coverage will be the secondary payer. Retiree coverage might fill some of the gaps in Medicare coverage and might offer additional benefits such as routine dental care. People who are not sure how their retiree coverage works with Medicare should get a copy of their plan's benefits booklet or look at the summary plan description provided by their employer or union. Workers approaching retirement should find out if employer coverage can be continued after they retire, and they should check the price and benefits, including benefits for a spouse. They should know what effect continuing coverage as a retiree will have on both their own and their spouse's insurance protections.

Retiree coverage provided by an employer or union may have limits on how much it will pay. It may also provide "stop loss coverage," a limit on out-of-pocket costs. They can also call the benefits administrator and ask how the plan pays when a person has Medicare.

Remember that the employer or union has control over the retiree insurance coverage it offers. The employer or union may change the benefits or the premiums and may also choose to cancel the insurance.

The Federal Employee Health Benefit Program (FEHBP) will be discussed later.

NOTE: For retirees with Medicare based on ESRD, Medicare may be secondary to retiree coverage for the 30-month coordination period.



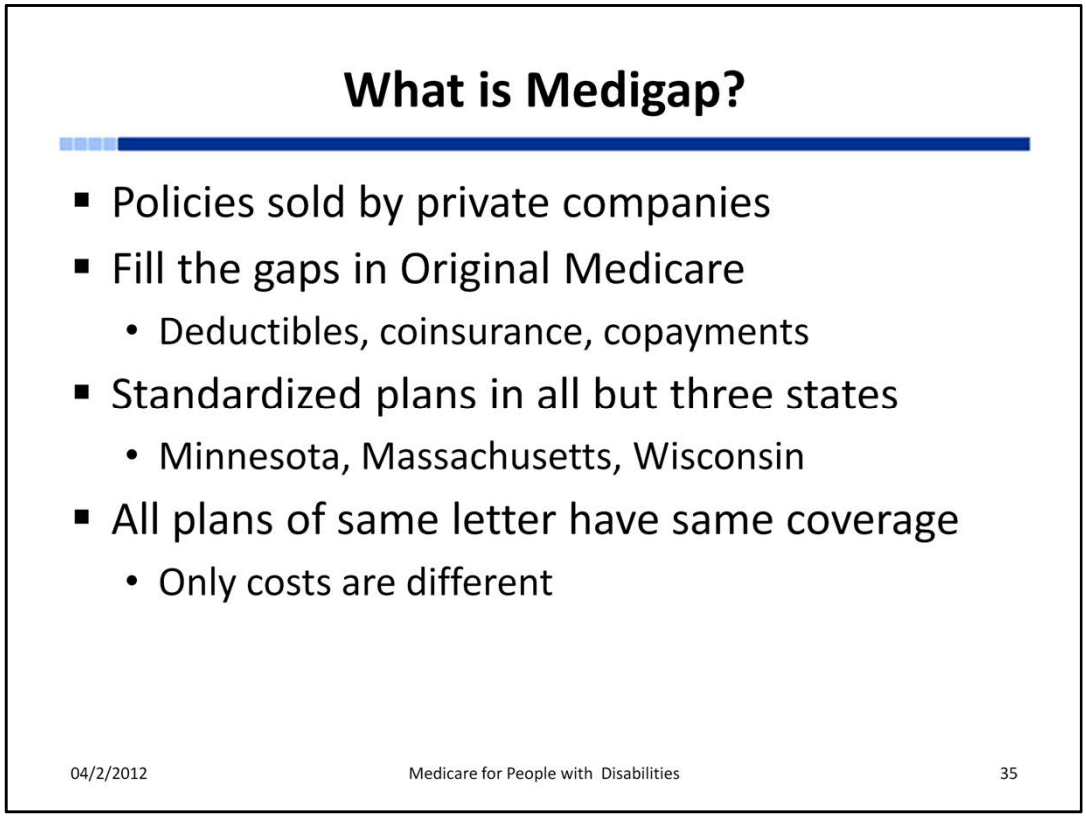
Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you will have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.

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 What Medicare Covers," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Medigap (Medicare Supplement Insurance) policies are private health insurance that cover only the policyholder, not the spouse. They are sold by private insurance companies to supplement Original Medicare (help pay for "gaps" in Original Medicare coverage - like deductibles, coinsurance and copayments).

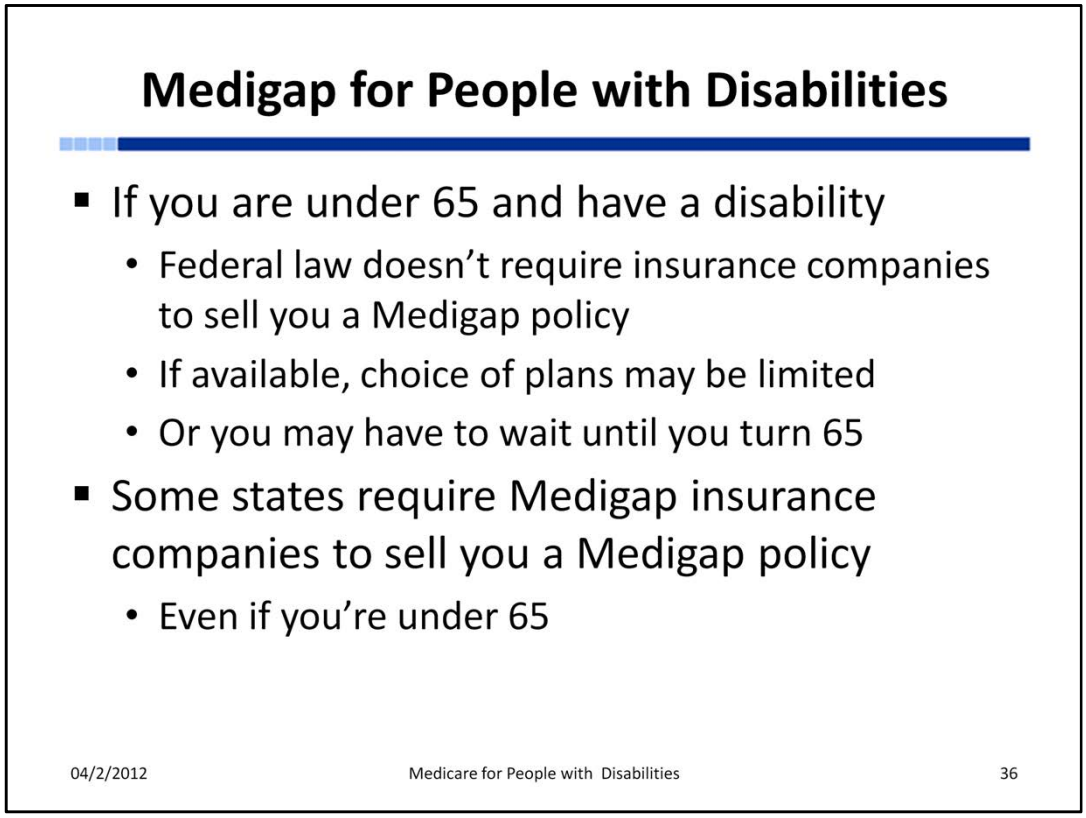
- They pay for Medicare-covered services provided by any doctor, hospital, or provider that accepts Medicare (the exception is Medigap SELECT policies that require you use specific hospitals, and in some cases, specific doctors to get full benefits).
- Medigap may cover certain things Medicare doesn't depending on the Medigap plan.
- They must follow Federal and state laws that protect people with Medicare.

In all states except Massachusetts, Minnesota, and Wisconsin, Medigap policies must be one of the standardized plans A, B, C, D, F, G, K, L, M or N so they can be easily compared. Each plan has a different set of benefits that are the same for any insurance company. It's important to compare Medigap policies, because costs can vary. (Note: Each company decides which Medigap policies it will sell and the price for each plan, with state review and approval).

A Medigap policy only works with Original Medicare (not with Medicare Advantage (MA) or other Medicare plans). It is illegal for anyone to sell you a Medigap policy if you

- Are in a Medicare Advantage Plan (unless your enrollment is ending).
- Have Medicaid (unless Medicaid pays for your Medigap policy or only pays your Medicare Part B premium).
- Already have a Medigap policy (unless you cancel your old Medigap policy).

You may want to drop your Medigap policy if you join a Medicare Advantage Plan or other Medicare plan. Even though you are entitled to keep it, it can't pay for benefits that you get under your MA or other Medicare plan and can't pay any cost-sharing under these plans.



At the time of printing this module, the following states required insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65: California*, Colorado, Connecticut, Delaware**, Florida , Georgia, Hawaii, Illinois, Kansas, Louisiana, Maine, Maryland, Massachusetts*, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont*, Wisconsin

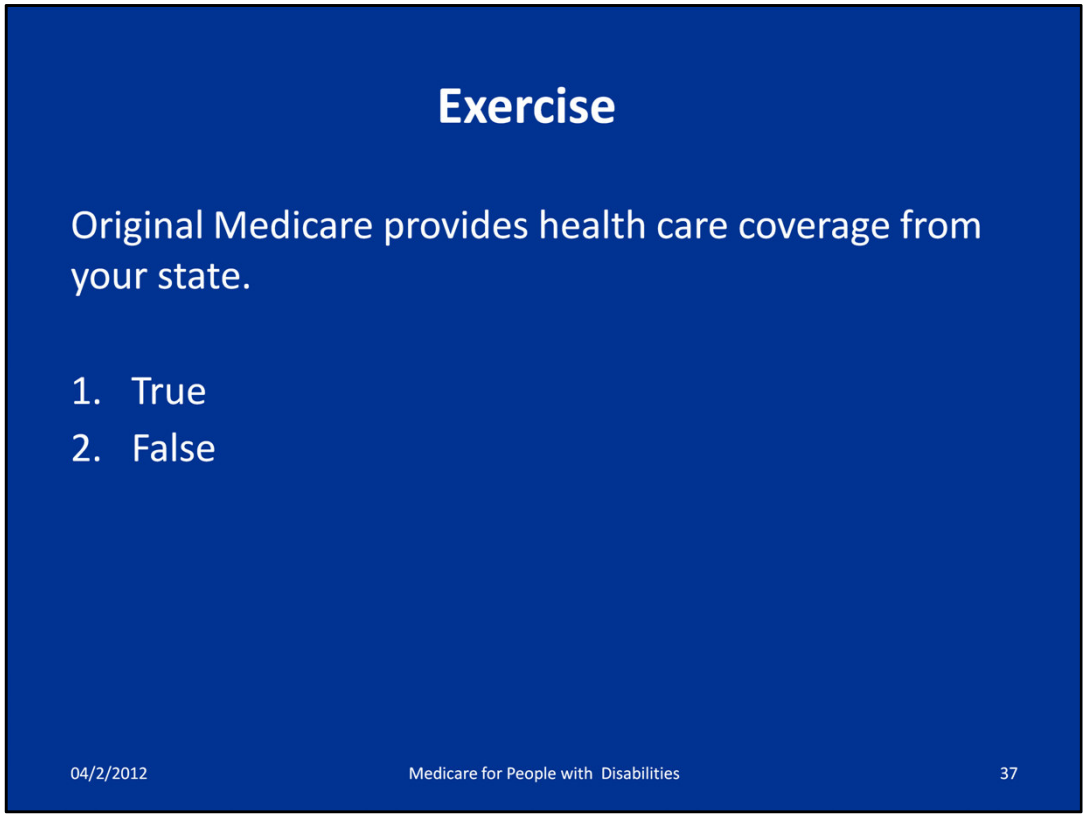
*A Medigap policy isn't available to people with ESRD under 65.

**A Medigap policy is only available to people with ESRD.

Even if your state isn't on the list above, some insurance companies may voluntarily sell Medigap policies to people under 65. They will probably cost you more than Medigap policies sold to people over 65, and they can use medical underwriting. Check with your state about what rights you might have under State law.

Remember, if you're already enrolled in Medicare Part B, you will get a Medigap Open Enrollment Period when you turn 65. You will probably have a wider choice of Medigap policies and be able to get a lower premium at that time. During the Medigap Open Enrollment Period, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Medicare (Part A and/or Part B) is creditable coverage. If you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period.



Exercise

Original Medicare provides health care coverage from your state.

1. True
2. False

Answer: 2. False.

Original Medicare is a Federal program administered by the Centers for Medicare & Medicaid Services.

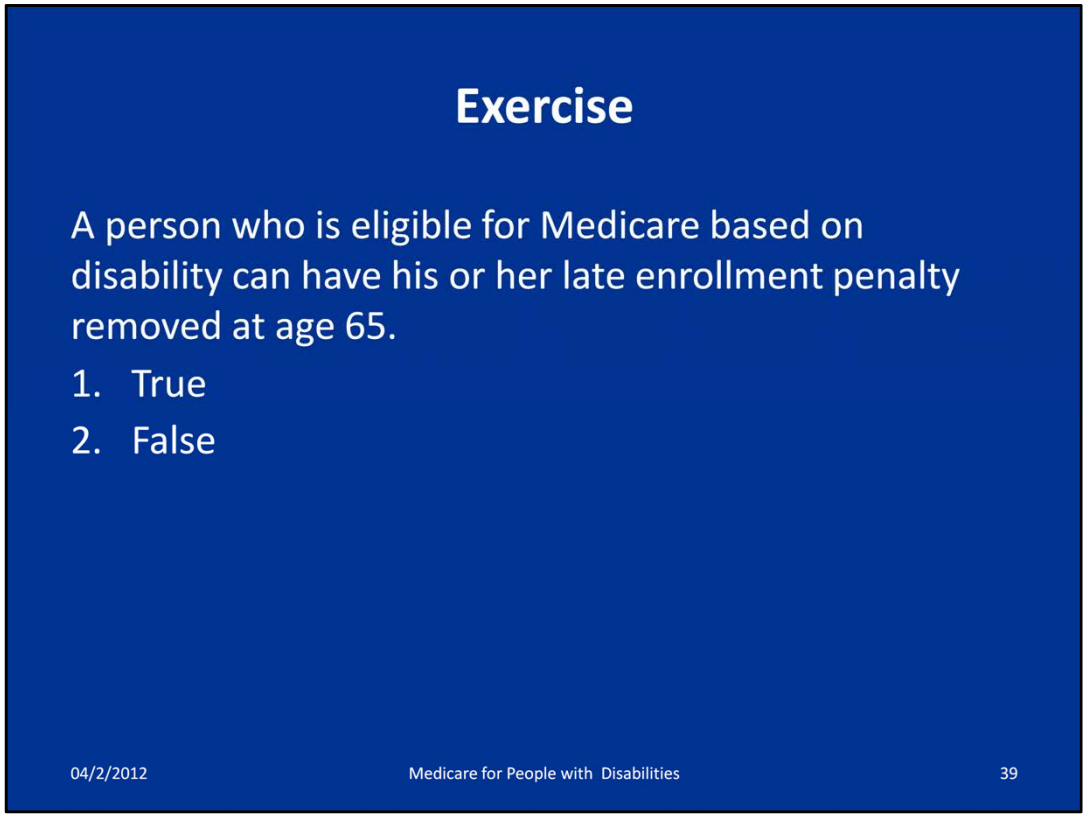
Exercise

Medigap policies may not be available to some people with disabilities.

1. True
2. False

Answer: 1. True

Federal law does not require all states to offer Medigap policies to people under age 65.



Exercise

A person who is eligible for Medicare based on disability can have his or her late enrollment penalty removed at age 65.

1. True
2. False

Answer: 1. True

A person who is eligible for Medicare based on a disability can have his or her late enrollment penalty removed once he or she turns 65, because the basis for entitlement has changed from disability to age.

Part C – Medicare Advantage

- Health plan options approved by Medicare
- Run by private companies
- Medicare pays plan amount for each member's care
- Another way to get Medicare coverage
- Part of the Medicare program
- You must have Part A and Part B to join
- May have to use network doctors or hospitals
- Can't join if you have ESRD (few exceptions)

Medicare Advantage is also called Part C. Medicare Advantage Plans are health plan options approved by Medicare and run by private companies.

Medicare pays amount for each member's care.

They are another way to get Medicare coverage.

They are part of the Medicare program.

You must have Medicare Part A and Medicare Part B to join a Medicare Advantage Plan.

If you join you may have to use network doctors or hospitals.

You cannot join a Medicare Advantage Plan if you have ESRD (there are a few exceptions).

How Medicare Advantage Works

- Still in Medicare
  - Get all Medicare rights and protections
- Still get Part A and Part B services
- Plan may include prescription drug coverage
- May include extra benefits like vision or dental
- Benefits and cost-sharing may be different
- Different types of plans, like HMOs and PPOs

If you join a Medicare Advantage Plan, you

- Still are in Medicare with all rights and protections
- Still get Part A and Part B services
- May have prescription drug coverage included
- May get extra benefits like vision or dental included
- Pay different amounts and may have different benefits
- Enrollment may be limited for people with ESRD
- They include different types of plans, like HMOs and PPOs.

Medicare Advantage Plan Costs

- Must still pay Part B premium
  - Some plans may pay all or part for you
  - Some people may be eligible for state assistance
- You may also pay monthly premium to plan
- You pay deductibles/coinsurance/copayments
  - Different from Original Medicare
  - Varies from plan to plan
  - May be higher if you go out of network

If you join a Medicare Advantage 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.

You may pay an additional monthly premium to plan.

You pay deductibles, coinsurance and copayments.

- Different from Original Medicare
- Varies from plan to plan
- May be higher if you go out of network

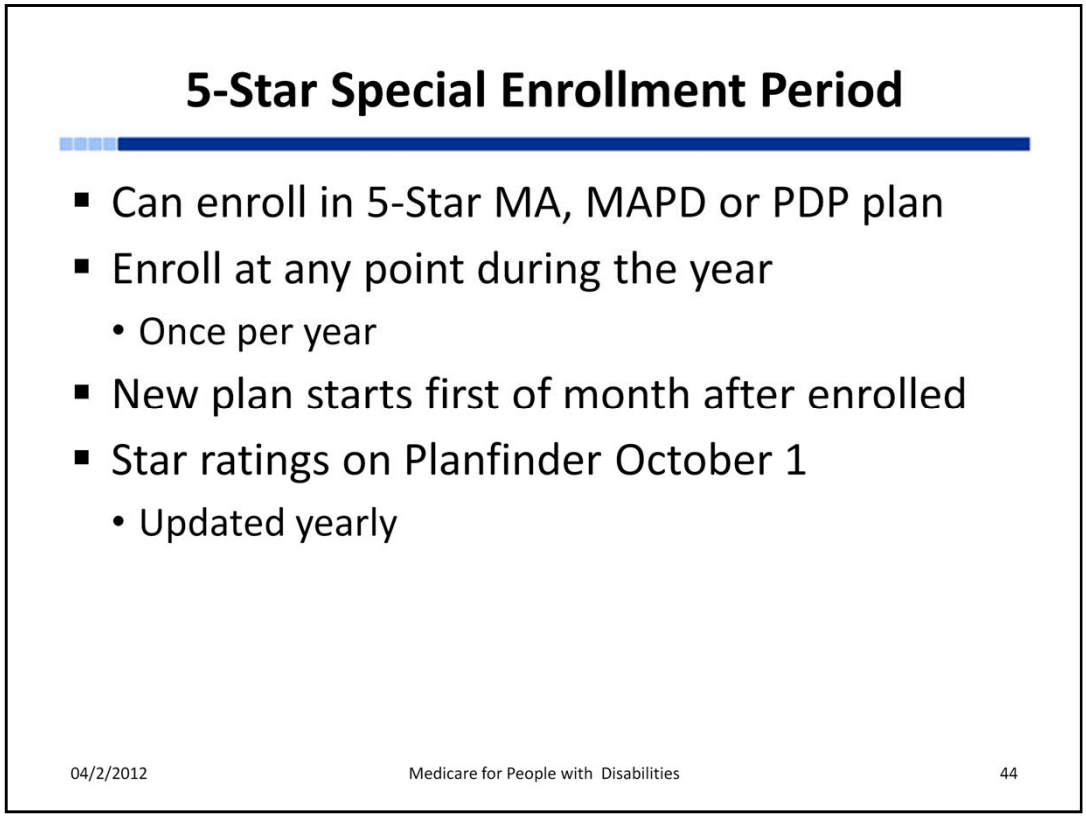
When Can People with a Disability Join or Switch Medicare Advantage Plans?

- Initial Enrollment Period
  - 3 months before 25th month of disability benefits
  - Those with ALS immediately
- Another IEP when you turn 65
- Open Enrollment Period
  - October 15 – December 7
  - Coverage begins January 1st of the following year
- Special Enrollment Period
  - Move from the plan service area and can't stay in the plan
  - Plan leaves Medicare program
  - Other special situations

You can join a Medicare Advantage Plan when you first become eligible for Medicare, during your Initial Enrollment Period, which begins three months immediately before your first entitlement to both Medicare Part A and Part B, or during the Open Enrollment Period, and in certain special situations that provide a Special Enrollment Period.

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

You can switch to another Medicare Advantage Plan or to Original Medicare during the Open Enrolment Period from October 15 – December 7.



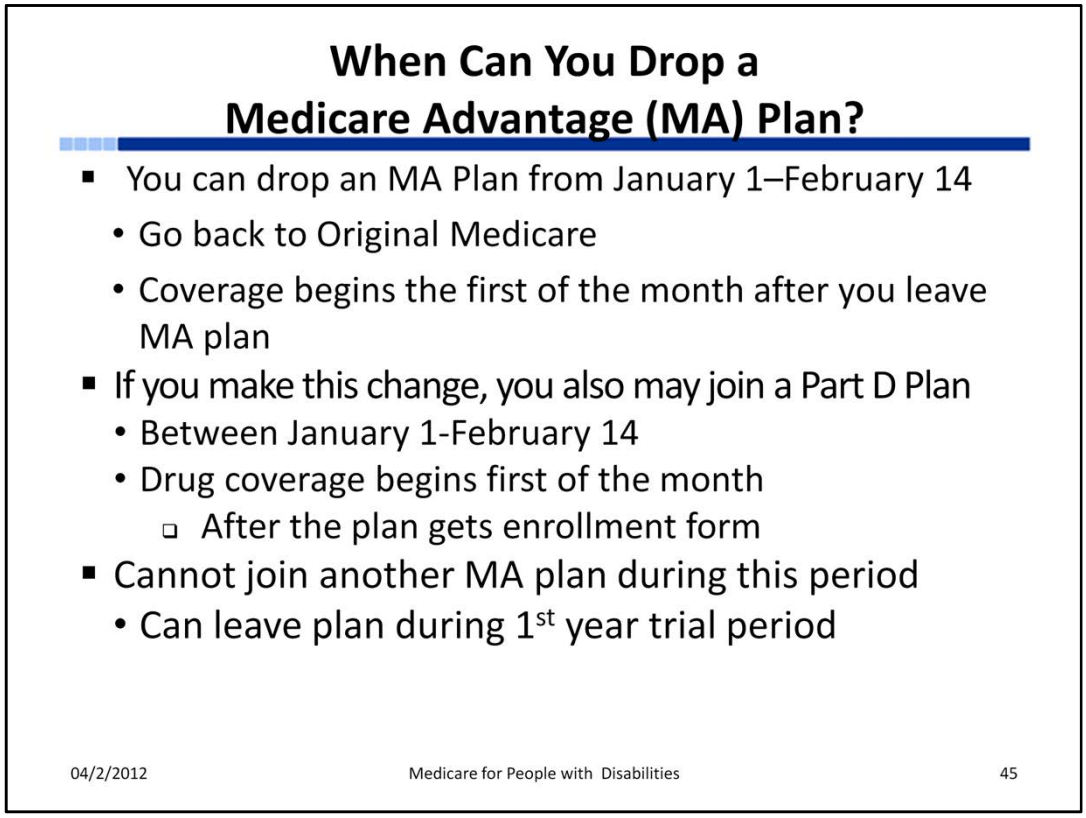
CMS announced the establishment of a Special Enrollment Period (SEP) that will allow Medicare beneficiaries eligible for MA plans to enroll in a 5-star MA plan at any point during the year. The general parameters of the SEP are as follows:

- For purposes of the SEP, an MA, MAPD, or PDP must have 5 stars as of the 2011 Open Enrollment Period (OEP), regardless of the rating used for purposes of 2012 quality bonus payments.
- As currently constituted, the new SEP will apply only for purposes of enrolling in a 5-star MA or MAPD plan or in a 5-star stand-alone Part D plan (not any other Medicare health plan) under this Special Enrollment Period.
- Individuals will be eligible for this SEP if they are either enrolled in MA plan, or enrolled in Original Medicare, and meet the MA eligibility requirements. Note: Eligible beneficiaries already enrolled in a 5-star MA plan **are** eligible to change to another 5-star plan during the SEP.

Enrollment requests made using this SEP will be effective the first of the month following the month the enrollment request is received. Once an individual enrolls in a 5-star plan, the individual's SEP ends for that plan year, and the individual will be limited to making changes only during other applicable election periods (e.g., Open Enrollment Period or another valid SEP). Individuals will be able to enroll in 5-star plans directly through the plan, through 1-800-MEDICARE or www.medicare.gov.

Plans that have received an overall 5-star rating will be required to accept these SEP requests, similar to any other SEP or initial enrollment for a newly eligible individual, unless the plan is closed per a CMS-approved capacity limit.

To find rating information, visit www.medicare.gov to compare plans.



You can join a Medicare Advantage Plan when you first become eligible for Medicare, during your Initial Coverage Election Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B, or during the Open Enrollment Period, and in certain special situations that provide a Special Enrollment Period.

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

You can switch to another Medicare Advantage Plan or to Original Medicare during the Open Enrollment Period from October 15 – December 7.

- **New:** If you belong to an MA plan, you can switch to Original Medicare from January 1 – February 14. If you go back to Original Medicare during this time, plan coverage 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 organization
  - Call 1-800-MEDICARE
  - Enroll in a stand alone PDP
- 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.

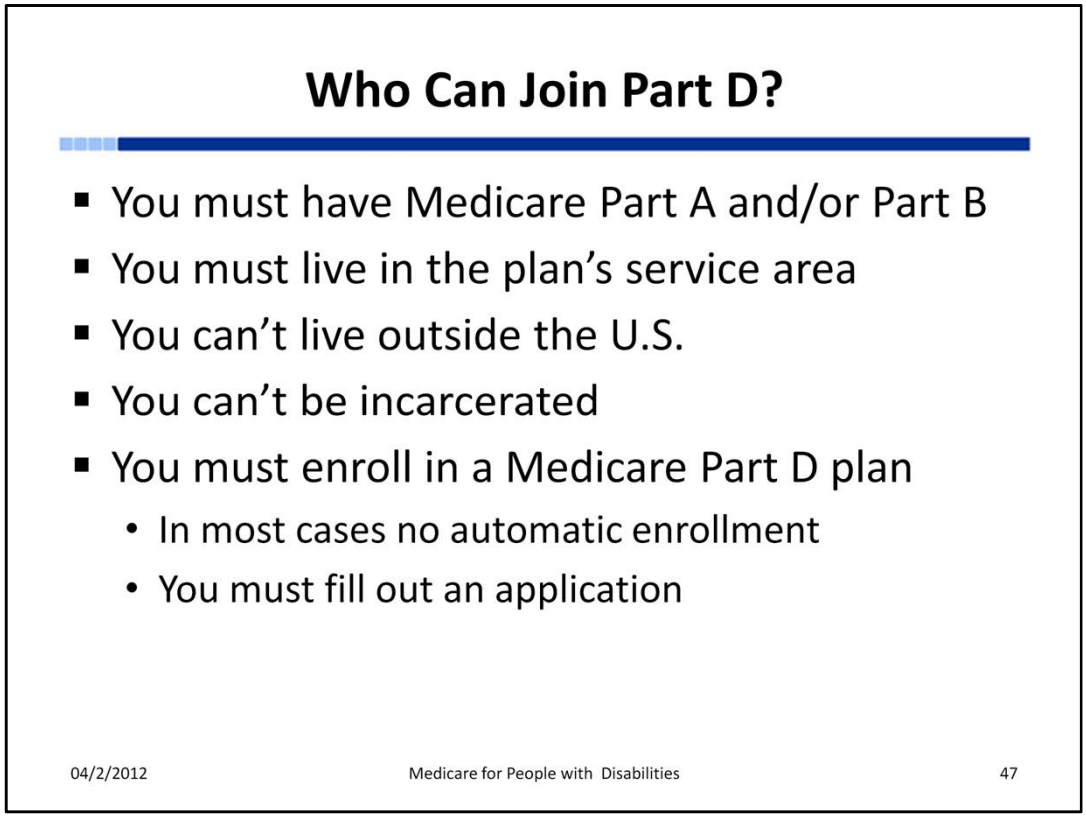
Part D – Medicare Prescription Drug Coverage

- Available for ***all*** people with Medicare
- Provided through
  - Medicare Prescription Drug Plans
  - Medicare Advantage Plans
  - Other Medicare plans
- Must include range of drugs in each category

Medicare Part D is Medicare Prescription Drug Coverage. It is available for all people with Medicare.

The coverage is provided through Medicare Prescription Drug Plans, Medicare Advantage Plans, or other Medicare plans.

Part D plans must cover a range of drugs in each category.



Part D is available for all people with Medicare. You can just have Part A, just have Part B, or have both.

You must live in the plan's service area.

You can't live outside the U.S.

You can't be incarcerated.

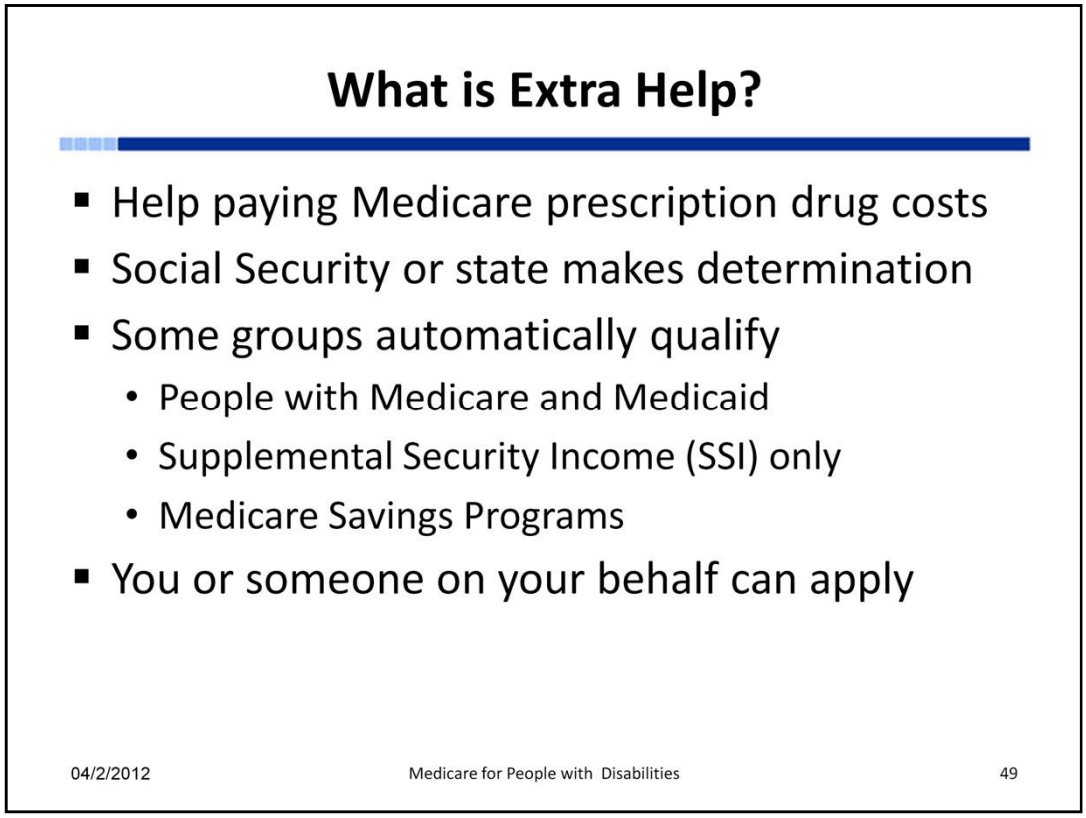
You must enroll in the plan yourself in most cases by completing an application. Some people with limited income and resources are automatically enrolled.

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

People with Medicare can also enroll in a Medicare Part D plan during the Annual Coordinated Enrollment Period, October 15 – December 7 each year. You can also change Medicare Part D plans during the Annual Coordinated Election Period.

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 Part D 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.



People with Medicare who have limited income 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 you apply, if you qualify you'll get a letter telling you if you qualify for Extra Help.

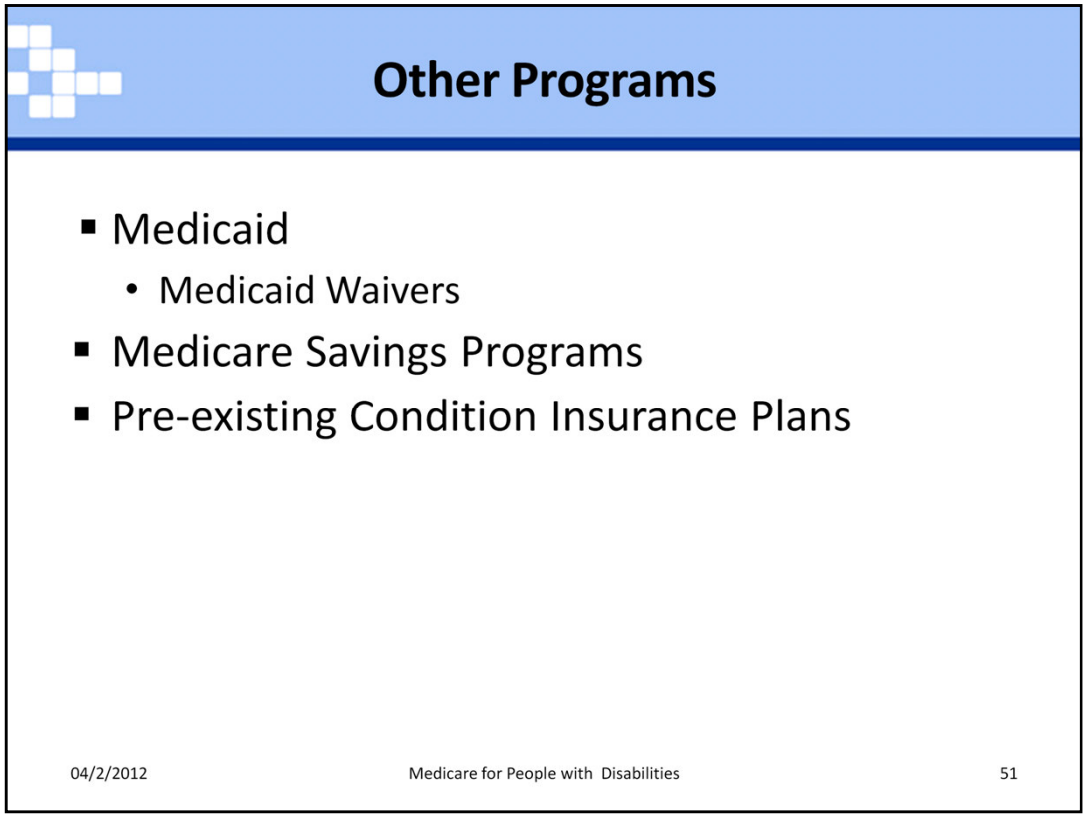
Certain groups of people automatically qualify for Extra Help and do not have to apply:

- 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. You may fill out a paper application, apply on the web at socialsecurity.gov, or apply through your State Medical Assistance office or a local organization. You or someone on your behalf can apply.

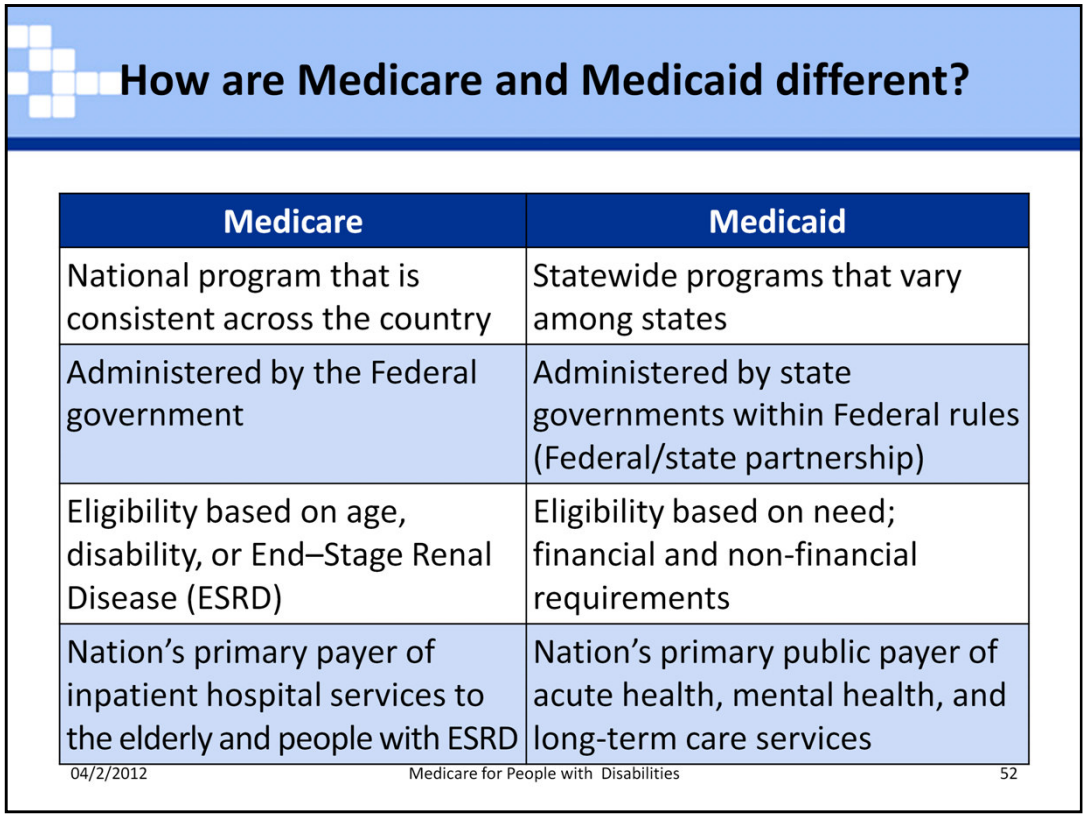
Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses:

- 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
  - 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.



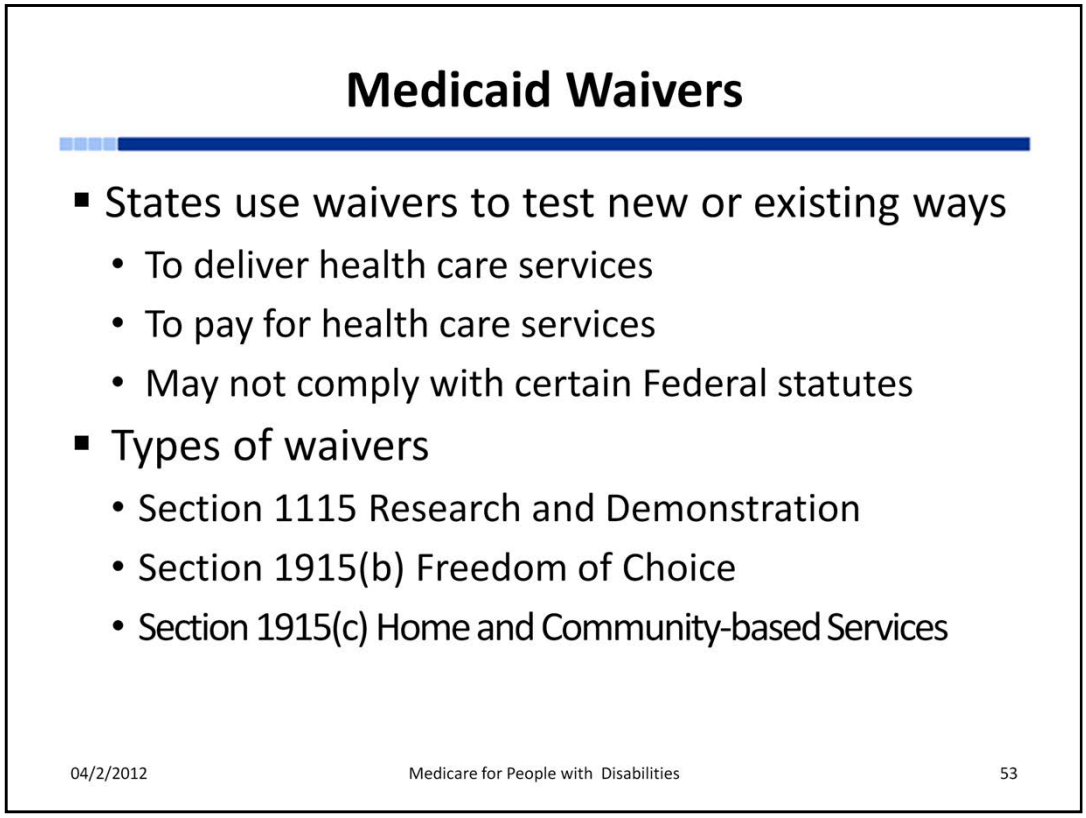
There are additional programs that may help people with disabilities pay for health and prescription drug care. They include

- Medicaid (and Medicaid waivers)
- Medicare Savings Programs
- Pre-existing Condition Insurance Plans



Medicare and Medicaid are different in the following ways:

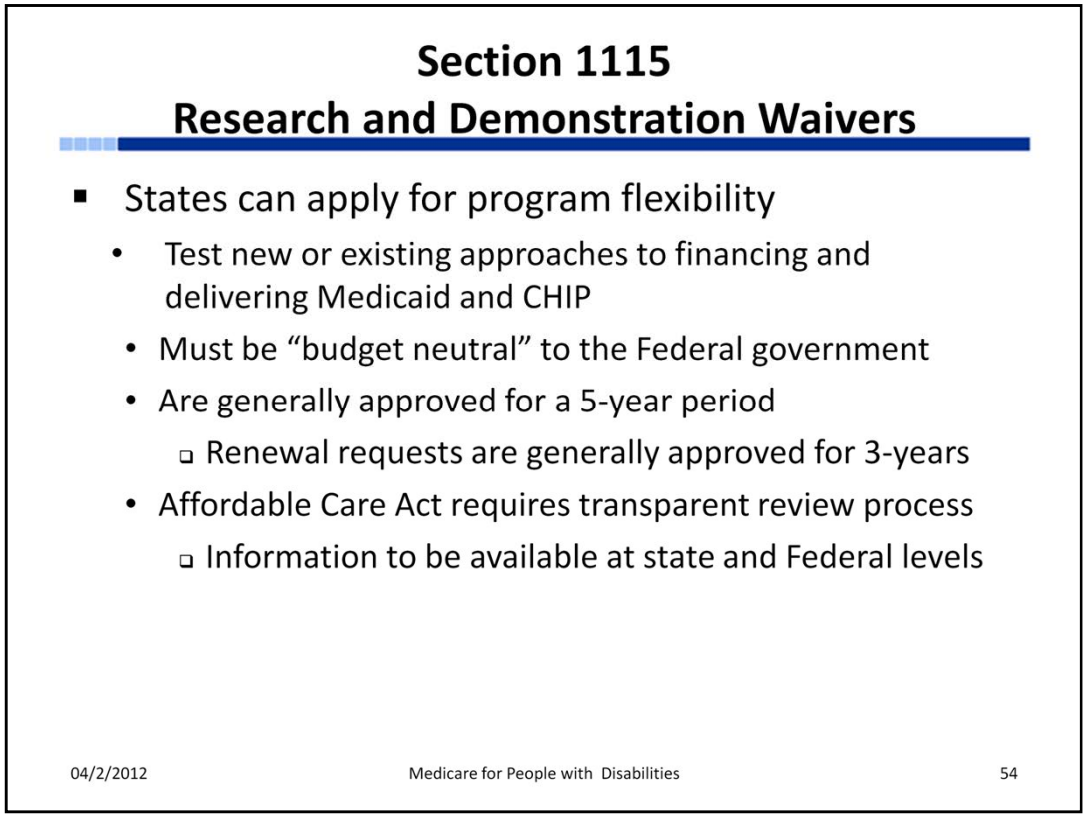
- While Medicare is a national program that is consistent across the country, Medicaid consists of statewide programs that vary among states.
- While Medicare is administered by the Federal government, Medicaid is administered by state governments within Federal rules (Federal/state partnership).
- While Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD), Medicaid eligibility is based on income and resources.
- While Medicare is the nation's primary payer of inpatient hospital services to the elderly and people with ESRD, Medicaid is the nation's primary public payer of acute health, mental health, and long-term care services.



Medicaid waivers allow the state to receive Federal Medicaid matching funds for its expenditures that normally would not be covered, even though it is no longer in compliance with certain requirements or limitations of the Federal Medicaid statute.

Waivers allow states alternatives to delivering care from traditional Medicaid.

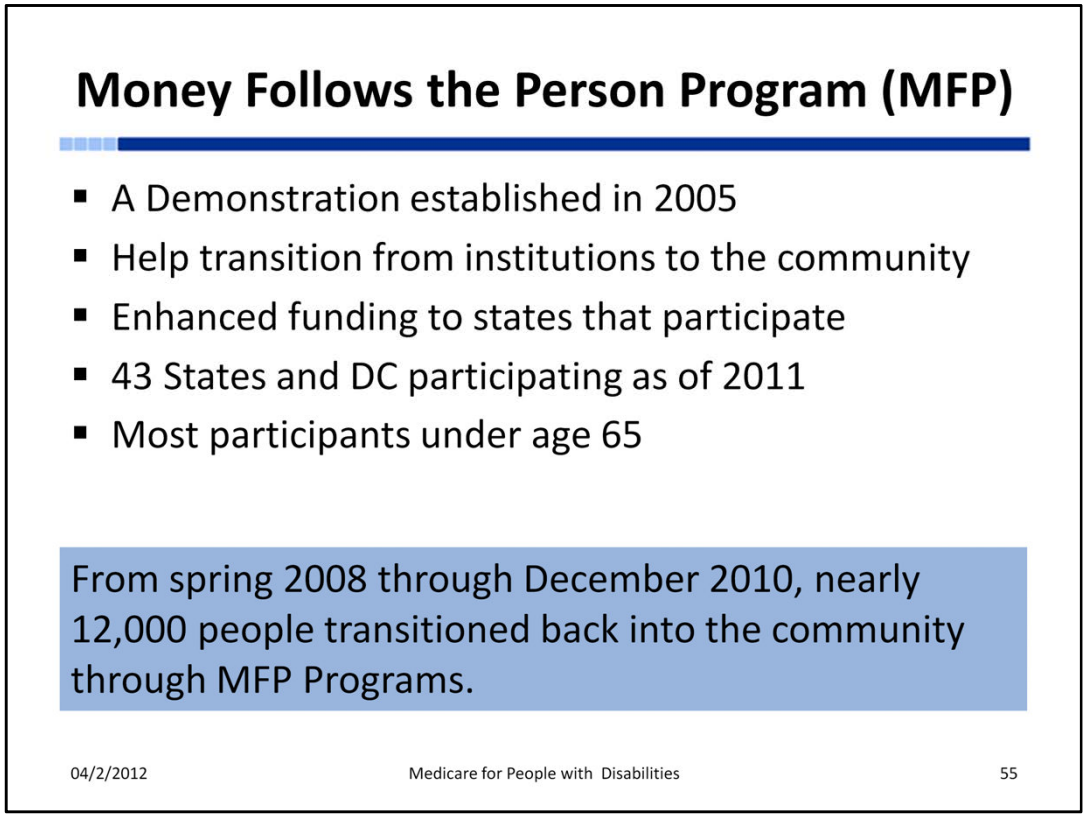
- Section 1915(b) waivers—states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.
- Program waivers such as the 1915(c) waiver for home-and community-based services–– states may receive Federal matching funds for services for which Federal matching funds are not otherwise available.
- Demonstration waivers such as the section 1115 waivers—states may receive Federal matching funds for covering certain categories of individuals for which Federal matching funds are not otherwise available.



Budget Neutrality Requirement - Waivers must be "budget neutral" to the federal government. The state must show that over the duration of the entire waiver, the federal Medicaid expenditures won't exceed what the federal government would have spent without the waiver.

Approval Period - Waivers are generally approved for a five-year period, but states typically submit renewal requests to continue the program beyond this time period. Waiver renewals are generally approved for three years.

Transparency - The Affordable Care Act of 2010 requires a transparent review process for 1115 Waivers. A final rule, effective on April 27, 2012, establishes a process to ensure public input into the development, review, and approval (or extension) of 1115 Waivers. This final rule sets standards to make information about Medicaid and CHIP Demonstration applications and approved Demonstration projects publicly available at the state and Federal levels.



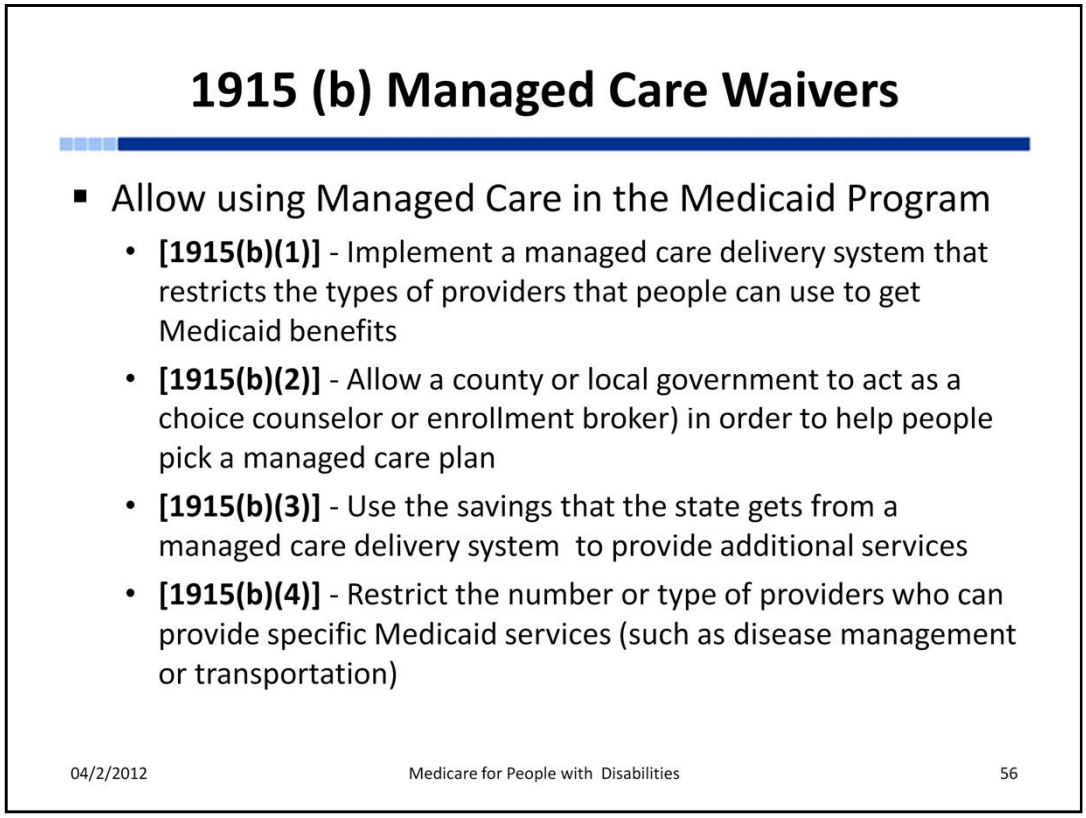
The Money Follows the Person program was established by Congress through the Deficit Reduction Act of 2005 (DRA).

Provides states with an opportunity to help Medicaid beneficiaries living in long-term care institutions for at least six months to return to the community.

States receive enhanced Federal matching rate for state Medicaid spending on home and community-based services provided to MFP program enrollees.
In 2007 CMS awarded grants to 31 states. States participating in MFP are: AR, CA CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV and the District of Columbia

As of June, 2010, the largest group of MFP participants has been people with disabilities under age 65.

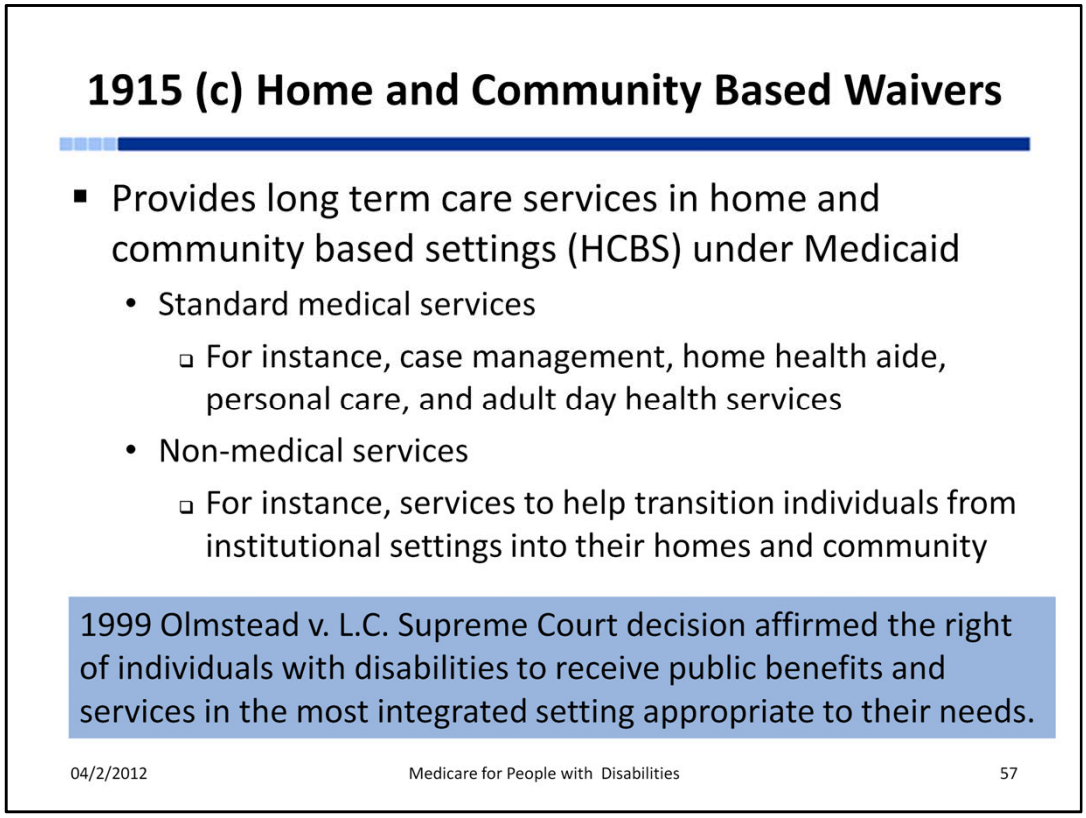
For more information on Money Follows the Person, visit our website at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html.



1915 (b) Managed Care Waivers

Allow using Managed Care in the Medicaid Program

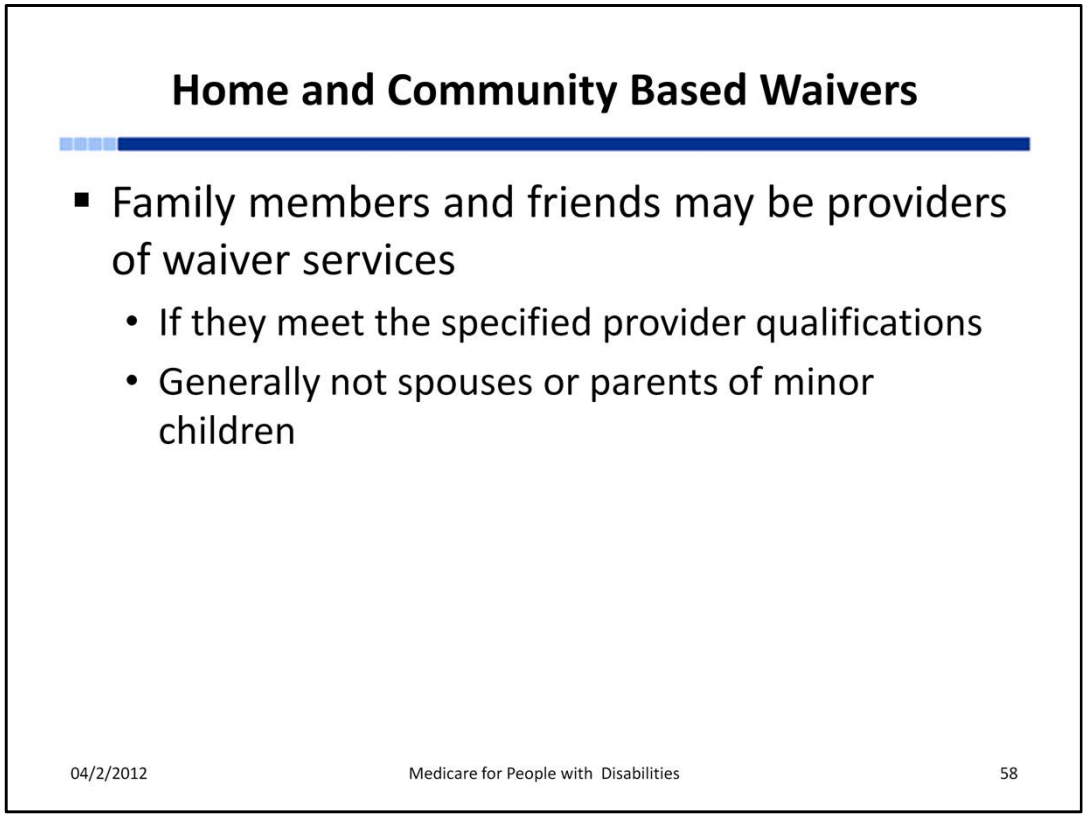
- **[1915(b)(1)]** - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- **[1915(b)(2)]** - Allow a county or local government to act as a choice counselor or enrollment broker) in order to help people pick a managed care plan
- **[1915(b)(3)]** - Use the savings that the state gets from a managed care delivery system to provide additional services
- **[1915(b)(4)]** - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation)



HCBS Waivers Section 1915 (c) - The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

In the 1999 Olmstead v. L.C. decision, the Supreme Court affirmed the right of individuals with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. The Olmstead v. L.C. decision interpreted Title II of the American with Disabilities Act (ADA) and its implementing regulations. Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The HCBS waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients.

Forty-eight states and the District of Columbia offer services through HCBS waivers, and Arizona operates a similar program under section 1115 research and demonstration authority. There is no Federal requirement limiting the number of HCBS waiver programs a state may operate at any given time, and currently there are approximately 287 active HCBS waiver programs in operation throughout the country.



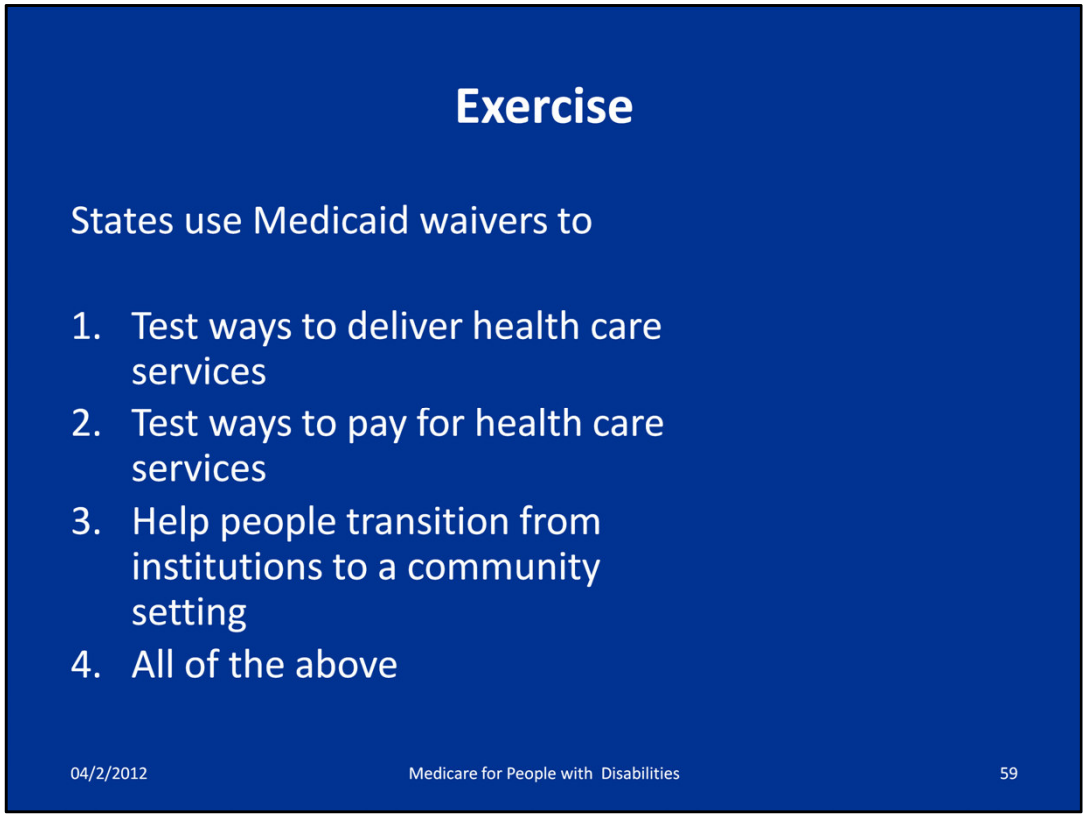
Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services.

States have the discretion to choose the number of consumers to serve in a HCBS waiver program. Once approved by CMS, a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval.

The state Medicaid agency must submit to CMS for review and approval an application for an HCBS waiver, and the state Medicaid agency has the ultimate responsibility for an HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity. Initial HCBS waivers are approved for a three-year period, and waivers are renewed for five-year intervals. In the parameters of broad Federal guidelines, states have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement an HCBS waiver program include

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care.

For more information visit
https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp



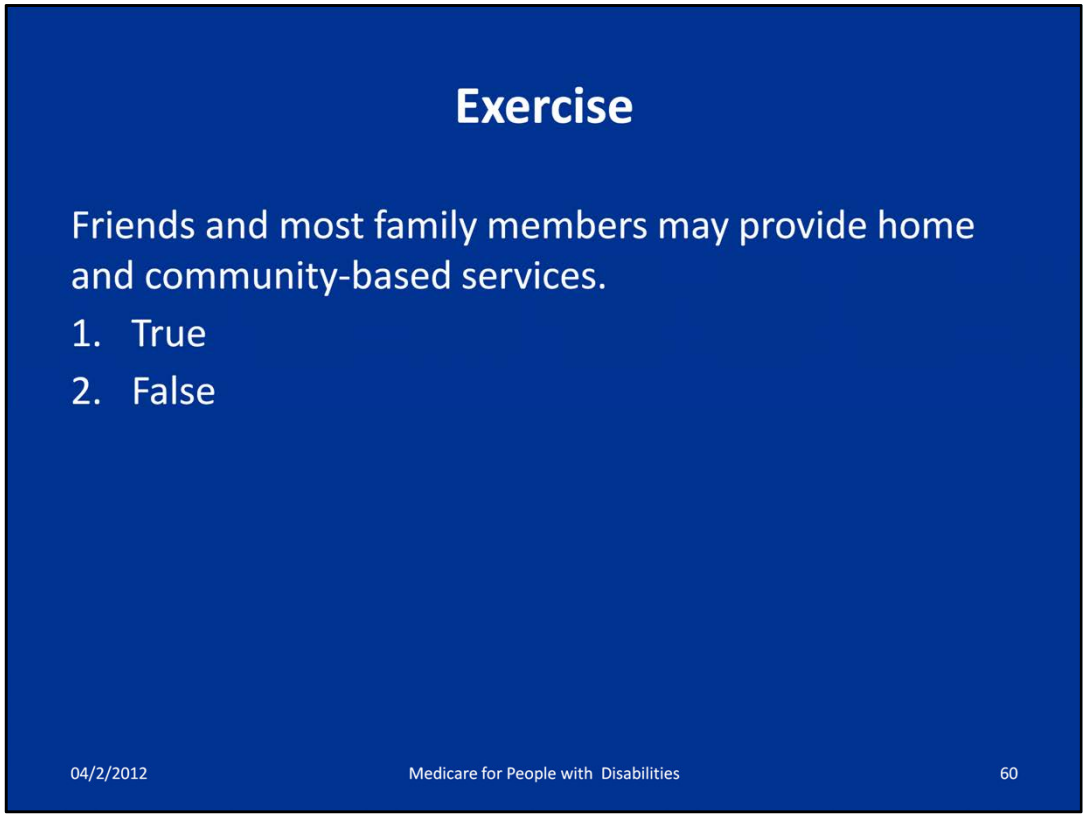
Exercise

States use Medicaid waivers to

1. Test ways to deliver health care services
2. Test ways to pay for health care services
3. Help people transition from institutions to a community setting
4. All of the above

Answer: 4. All of the above.

Medicaid waivers test different ways to deliver health care services, alternative payment methods and help people transition from institutions to a community setting.

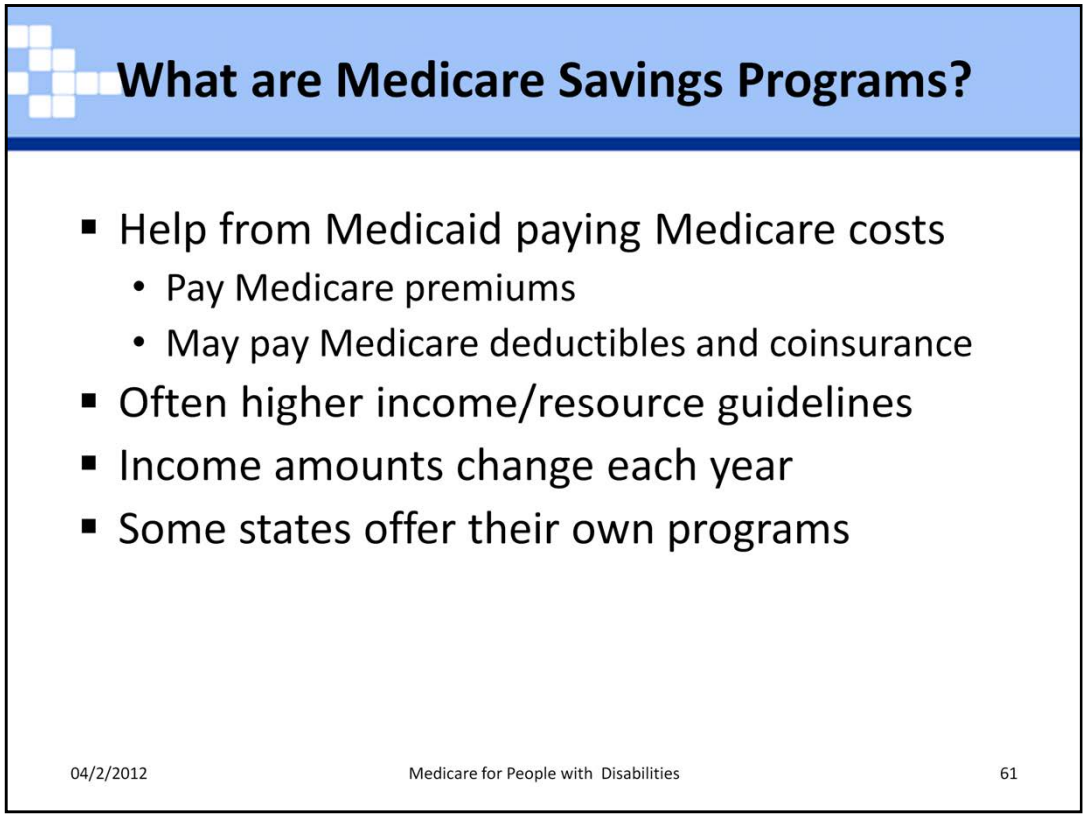


Exercise
Friends and most family members may provide home and community-based services.

1. True
2. False

Answer: 1. True

Friends and family members may be providers of home and community-based services. However, spouses and parents of minor children generally cannot be providers of these services.

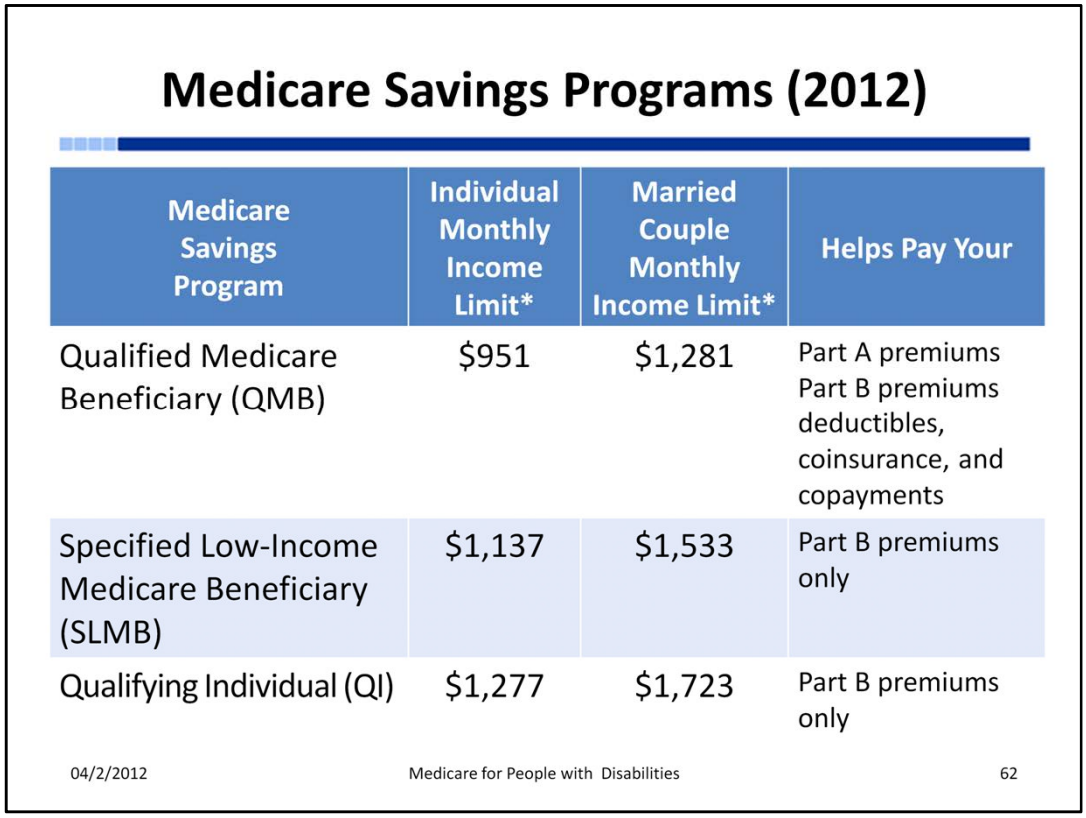


Medicare Savings Programs provide help from State Medicaid programs with paying for Medicare costs. These programs can help pay Medicare premiums, deductibles, and/or coinsurance.

These programs often have higher income/resource guidelines.

Income amounts can change each year.

Some states offer their own programs.

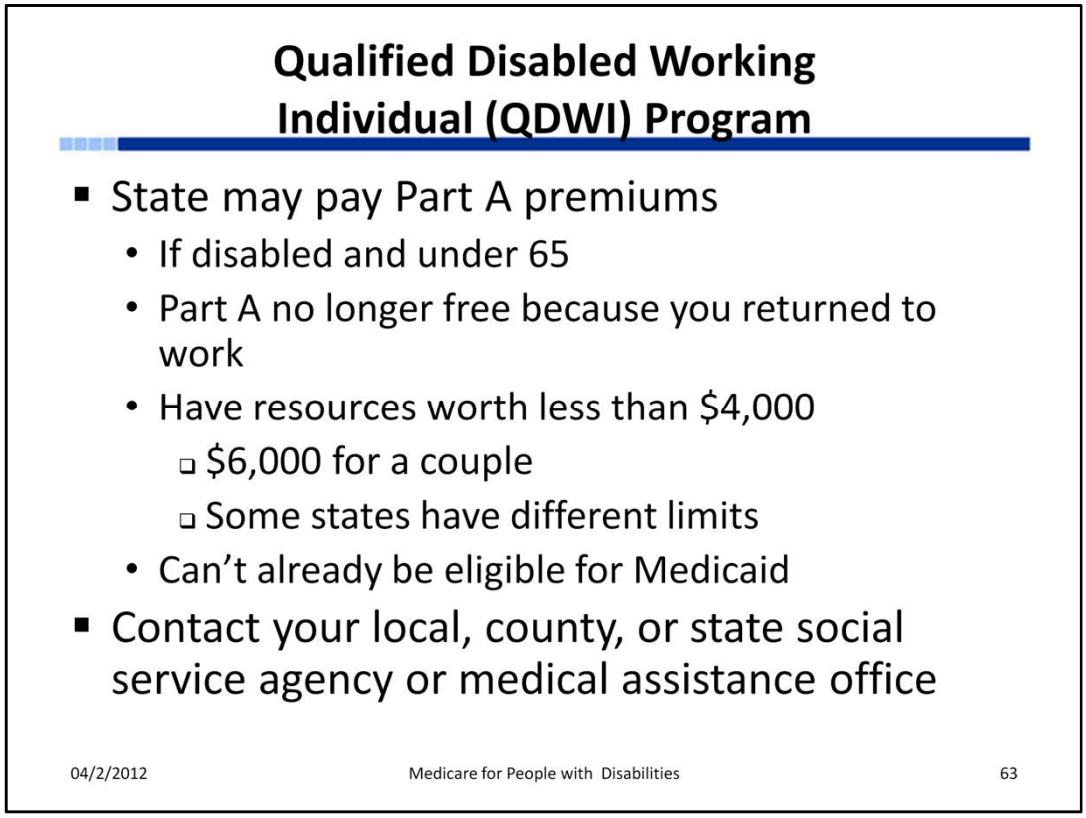


The Qualified Medicare Beneficiary (QMB) program was established by the Medicare Catastrophic Coverage Act of 1988. To qualify for QMB you must be eligible for Medicare Part A, and have an income not exceeding 100% of the Federal Poverty Level (FPL). This will be effective the first month following the month QMB eligibility is approved. Eligibility cannot be retroactive. If you qualify for QMB, you get help paying your Part A and Part B premiums, deductibles, co-insurance, and co-pays.

The Specified Low-income Medicare Beneficiary (SLMB) program was established by OBRA law of 1990 and became effective January 1, 1993. To qualify for SLMB, you must be eligible for Medicare Part A and have an income that is at least 100%, but does not exceed 120% of the FPL. If you qualify for SLMB, you get help paying for your Part B premium.

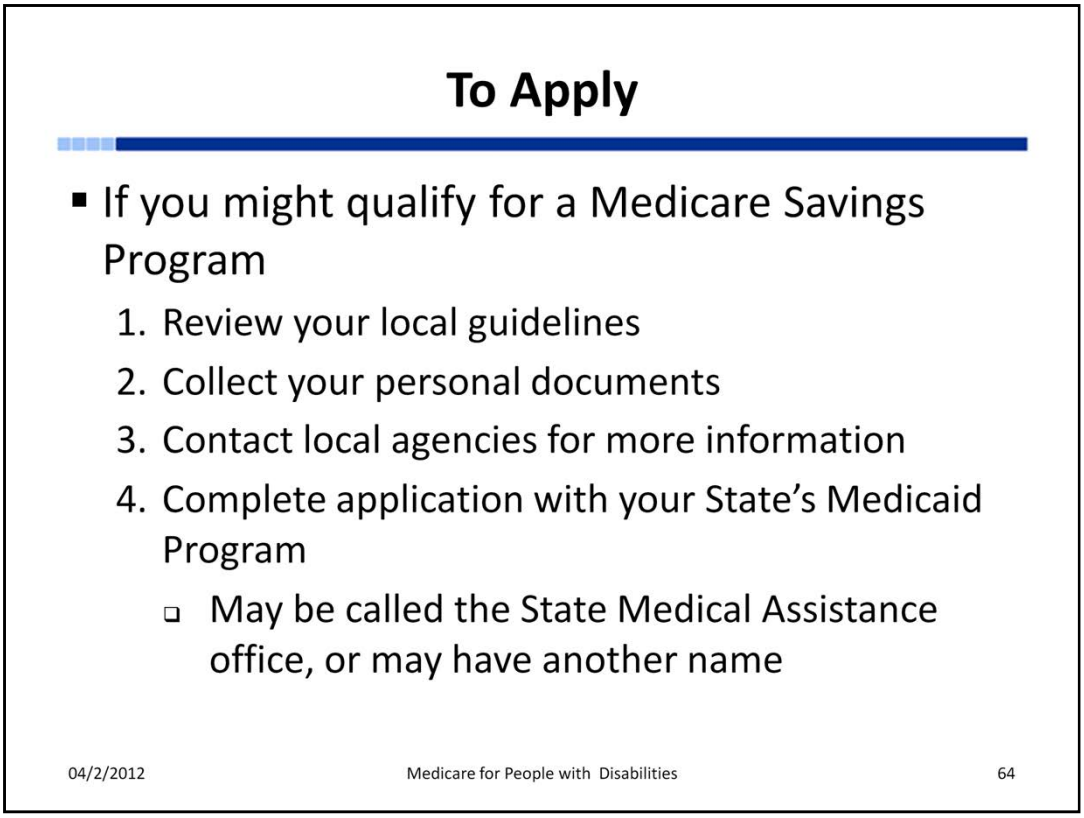
NOTE: In 2012, the resource limits for the QMB, SLMB and QI programs are $6,940 for a single person and $10,410 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year. States must use the new resource limits when determining eligibility for these programs.

The Qualified Individual (QI) program was established by the BBA of 1997. It is fully Federal funded. Congress only appropriated a limited amount of funds to each state. To qualify for QI, you must be eligible for Medicare Part A, and have an income not exceeding 135% of the Federal Poverty Level (FPL). If you qualify for QI, and there are still funds available in your state, you get help paying your Part B premium.



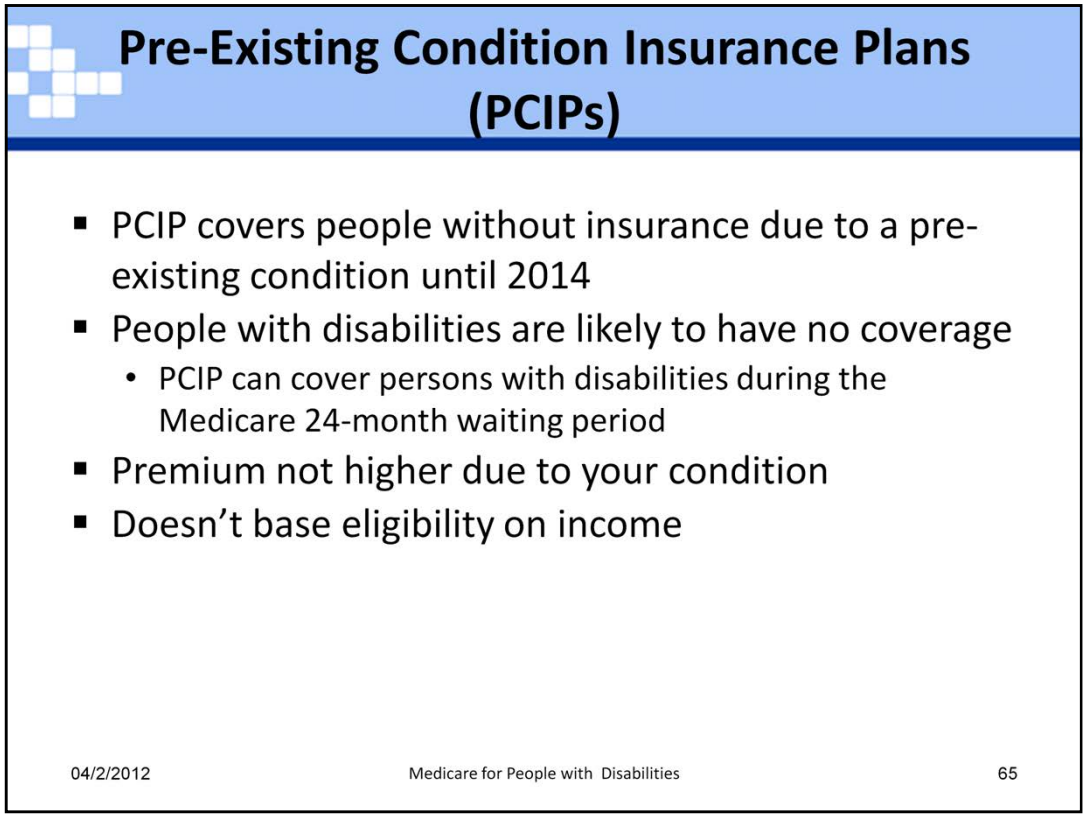
The Qualified Disabled Working Individual (QDWI) program will pay Medicare Part A premiums.

- If you are under age 65, disabled and no longer entitled to free Medicare Hospital Insurance Part A because you successfully returned to work, you may be eligible for a state program that helps pay your Medicare Part A monthly premium.
- To be eligible for this help, you must
  - continue to have a disabling impairment;
  - sign up for premium Hospital Insurance (Part A);
  - have limited income;
  - and not have resources worth more than $4,000 for an individual and $6,000 for a couple. (Your state will not count the home where you live, usually one car and $1,500 in burial expenses (per person) as resources); and
    not already be eligible for Medicaid.
- Some states have different limits.
- To find out more about the QDWI program, contact your local, county, or state social service agency or medical assistance office.



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

1. First, review the income and resource (or asset) guidelines for your area.
2. If you think you may qualify, collect the personal documents the agency requires for the application process. You will need
   - 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
3. You can get more information by contacting your State Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.
4. Finally, complete an application with your State Medical Assistance office.



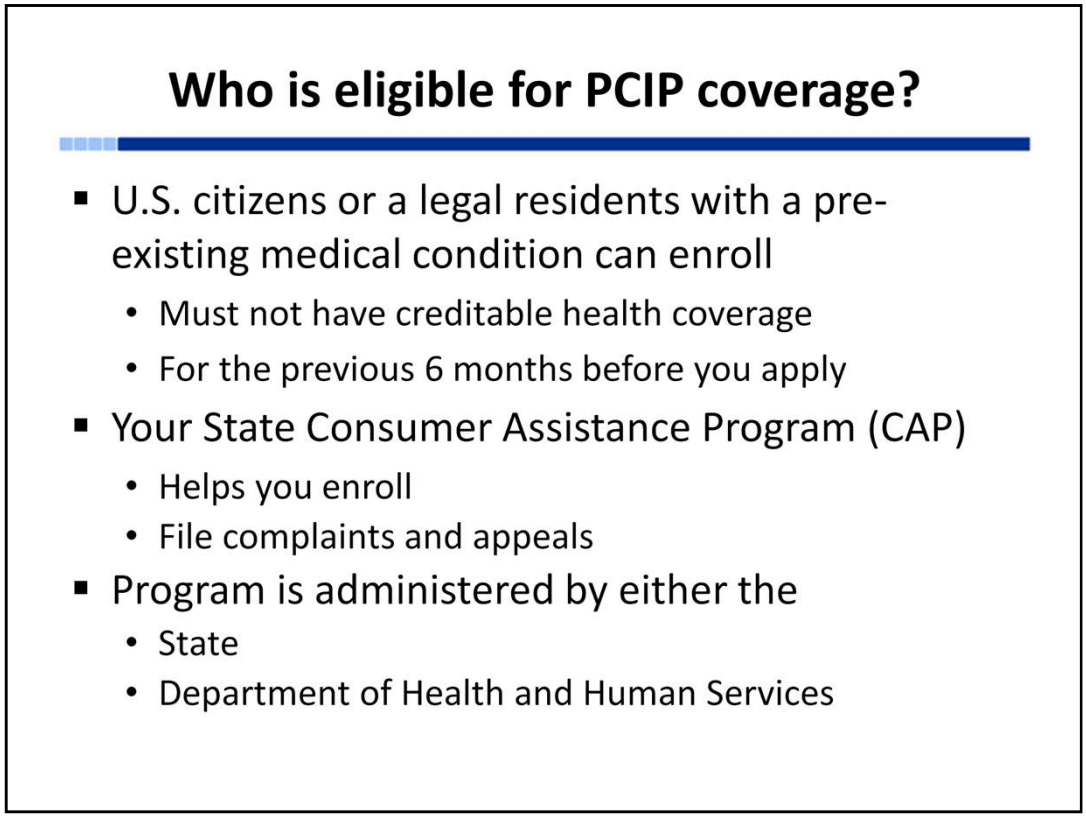
Pre-Existing Condition Insurance Plans (PCIPs) can cover persons with disabilities during the Medicare 24-month waiting period. PCIP is a "transitional" program because on January 1, 2014, health insurance companies will be prohibited from denying coverage due to a pre-existing condition. PCIP is a bridge until 2014 for people who have been denied health insurance by health insurance companies. At that time, enrollees in PCIP will transition into receiving health care coverage through new State-based health care exchanges.

PCIP, which is administered by either your State or the U.S. Department of Health and Human Services, provides a health coverage option if you have been uninsured for at least six months, you have a pre-existing condition or have been denied health coverage because of your health condition, and are a U.S. citizen or are residing here legally. An insurance rejection letter is no longer required, but a doctor must attest to your condition.

In 2014, you will have access to affordable health insurance choices through a new competitive marketplace called the Health Insurance Marketplace (Exchange) and you will no longer be discriminated against based on a pre-existing condition.

The Pre-Existing Condition Insurance Plan covers a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. PCIP doesn't charge you a higher premium just because of your medical condition, and it doesn't base eligibility on income.

See Section 1101 of the Affordable Care Act. Visit www.healthcare.gov for more information about PCIPs.



To be eligible for the Pre-Existing Condition Insurance Plan (PCIP), you must be a citizen or national of the United States or residing in the U.S. legally.

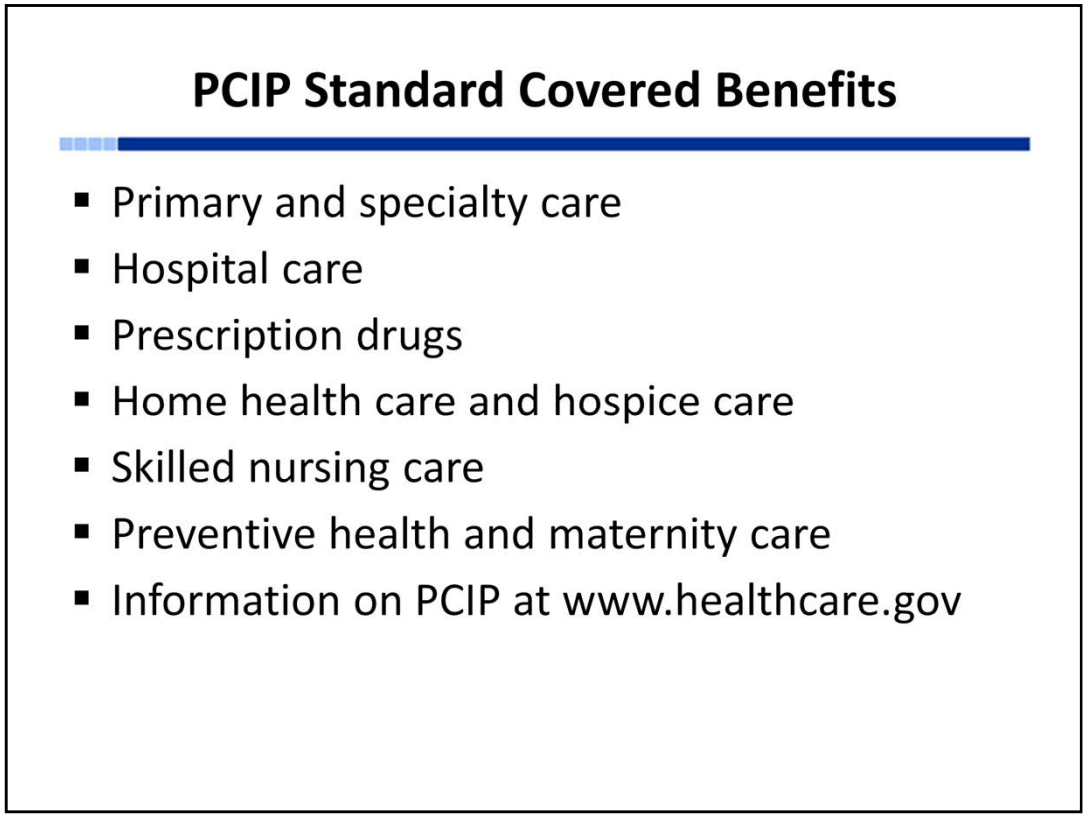
You must have been uninsured for at least the last six months. Please note that if you currently have insurance coverage that doesn't cover your medical condition or are enrolled in a state high risk pool, you are not eligible for the PCIP.

You must have a pre-existing condition or have been denied coverage because of your health condition.

If you're having trouble finding, keeping, or using health insurance, your state has a Consumer Assistance Program (CAP) that can help. Your CAP can help you enroll in a health insurance plan or policy, file a complaint and appeal, and help you learn about your rights and new industry reforms. CAP services are provided at no charge to you. CAPs also track consumer complaints to help identify widespread problems and strengthen enforcement. Your CAP is a grantee and may be a state agency, community agency, etc.

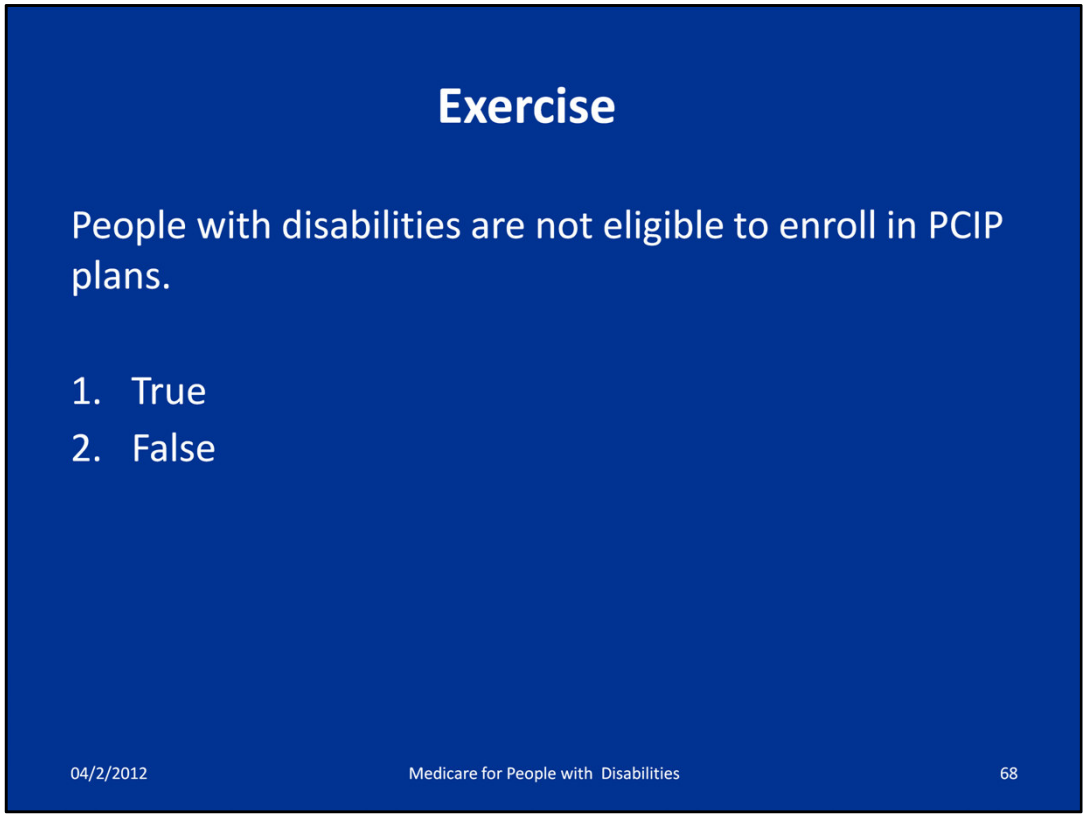
For more information visit www.pcip.gov or www.healthcare.gov

NOTE: Presenter may wish to provide information on CAP program in specific state.



Standard covered benefits include

- Primary and specialty care
- Hospital care
- Prescription drugs
- Home health care and hospice care
- Skilled nursing care
- Preventive health and maternity care
- See Section 1101 of the Affordable Care Act.
- Visit healthcare.gov for more information.



Exercise

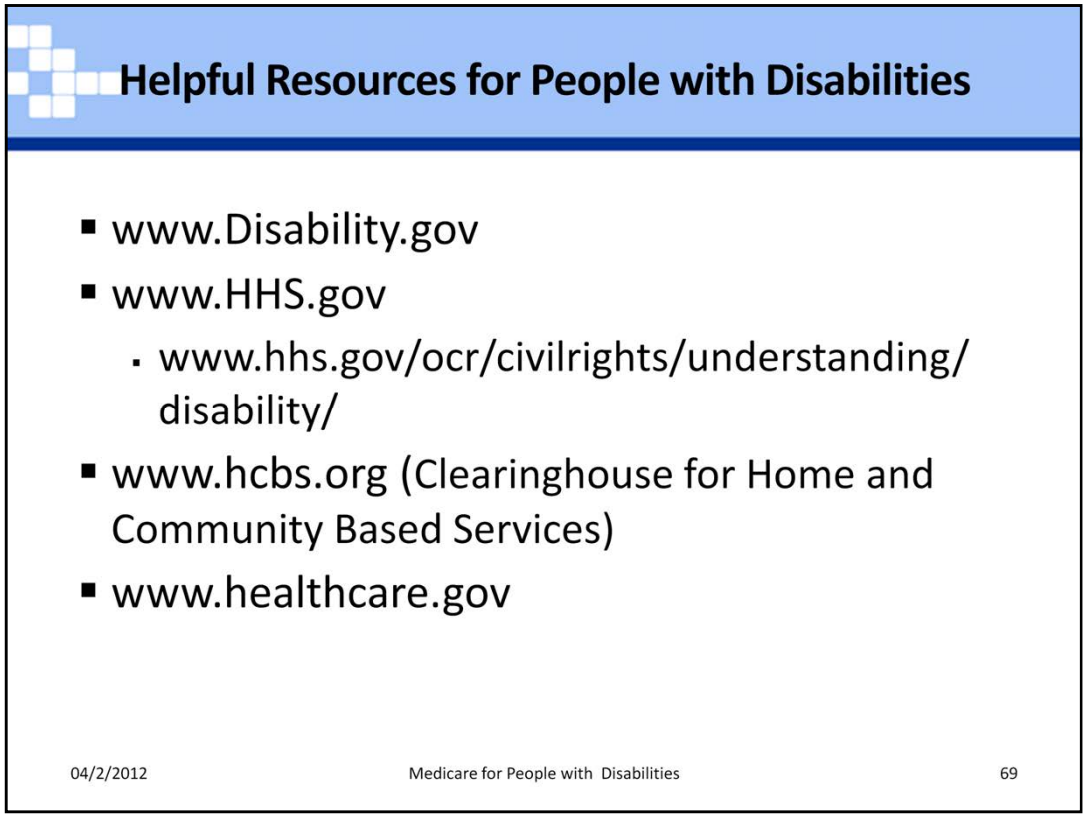
People with disabilities are not eligible to enroll in PCIP plans.

1. True
2. False

Answer: 2. False

PCIP plans can cover persons with disabilities during the Medicare 24-month waiting period.

The PCIP makes health insurance available to people who have had a problem getting insurance due to a pre-existing condition.



www.Disability.gov - Since July 2009, Disability.gov has implemented both social media and personalization tools, offering an enhanced experience for all visitors. Among the new features is the ability to register for a *My Disability.gov* profile, which allows users to vote and comment on resources, participate in group forums and view additional resources that are recommended based on their actions on the site.

www.HHS.gov - The Health and Human Services Office on Disability (OD) oversees the implementation and coordination of programs and policies that enhance the health and well-being of people with disabilities across all ages, races, and ethnicities. This website offers a wide range of resources for people with disabilities, including news and updates, training, and information on the Community Living Initiative.

- The Office of Civil Rights website is dedicated to helping people with disabilities understand their rights to nondiscrimination by offering fact sheets and information about specific topics for the general public and for providers.

www.HCBS.org - The Clearinghouse for Home and Community Based Services allows you to browse more than 2,000 resources on Home and Community Based Services (HCBS) resources, like in a bookstore. Visit http://www.hcbs.org/.

www.Ready.gov - Ready.gov provides tips for people with disabilities on how to plan for survival at home, in a shelter, or elsewhere in the event of an actual emergency. It includes many resources for emergency assistance at the Federal, state, and local level.

www.healthcare.gov – Provides information about insurance options and preventive services.

Disability Resource Guide

Government Resources	Industry Resources	Medicare Products
Medicare.gov www.socialsecurity.gov www.HHS.gov/od **Centers for Medicare & Medicaid Services (CMS)** 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) Social Security Administration 1-800-772-1213 (TTY 1-800-325-0778) U.S. Railroad Retirement Board www.rrb.gov	**State Health Insurance Assistance Programs (SHIPs)*** State Office on Aging *For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users	***Medicare & You Handbook*** CMS Product No. 10050) ***Your Medicare Benefits*** CMS Product No. 10116 **To access these products:** View and order single copies at Medicare.gov Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.

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Appendix A

Round 1 Rebid Competitive Bidding Areas

California	Riverside, San Bernardino, Ontario
Florida	Miami, Fort Lauderdale, Pompano Beach
Florida	Orlando, Kissimmee
Missouri and Kansas	Kansas City
North and South Carolina	Charlotte, Gastonia, Concord
Ohio	Cleveland, Elyria, Mentor
Ohio, Kentucky, and Indiana	Cincinnati, Middletown
Pennsylvania	Pittsburgh
Texas	Dallas-Fort Worth, Arlington

This chart lists the Round 1 Rebid Competitive Bidding Areas.

Appendix A

Competitive Bidding Areas for Round 2

Names of the CBAs for the Chicago, Los Angeles, and New York MSAs are:		
Chicago-Joliet-Naperville, IL-IN-WI	**Los Angeles-Long Beach-Santa Ana, CA**	**New York-Northern New Jersey-Long Island, NY-NJ-PA**
Central Chicago Metro, IL	Los Angeles County, CA	Bronx-Manhattan, NY
Indiana-Chicago Metro, IN	Orange County, CA	Nassau-Brooklyn-Queens, NY
Northern-Chicago Metro, IL-WI		North-West NYC Metro, NJ
South West Chicago Metro, IL		Northern NYC Metro, NY
		Southern NY Metro, NY-NJ
		Suffolk County, NY

This chart shows the names of the Competitive Bidding Areas (CBAs) for Chicago, Los Angeles, and New York.
Most Round 2 MSAs have only one CBA. However, the three largest Metropolitan Statistical Areas (Chicago, Los Angeles, and New York) are subdivided into multiple CBAs, so there are a total of 100 CBAs.