Workbook

2013 National Training Program

Module: 1
Understanding Medicare

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Module 1: Understanding Medicare

Contents

Contents

This module can be presented in 2.5-3 hours. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

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

The Centers for Medicare & Medicaid Services (CMS) developed and approved this training module. CMS is the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. Information in this module was correct as of May 2013.

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

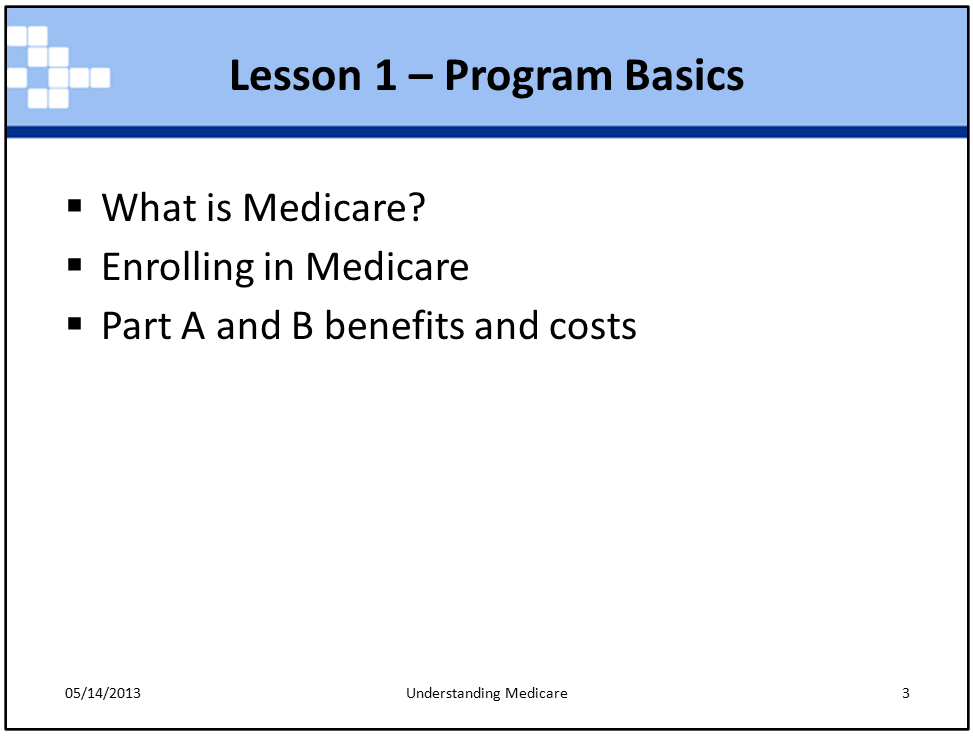
To check for updates on the new health care legislation, visit www.healthcare.gov.

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

This set of CMS National Training Program materials isn't a legal document. Official Medicare program provisions are contained in the relevant statutes, regulations, and rulings.

This session will help you to

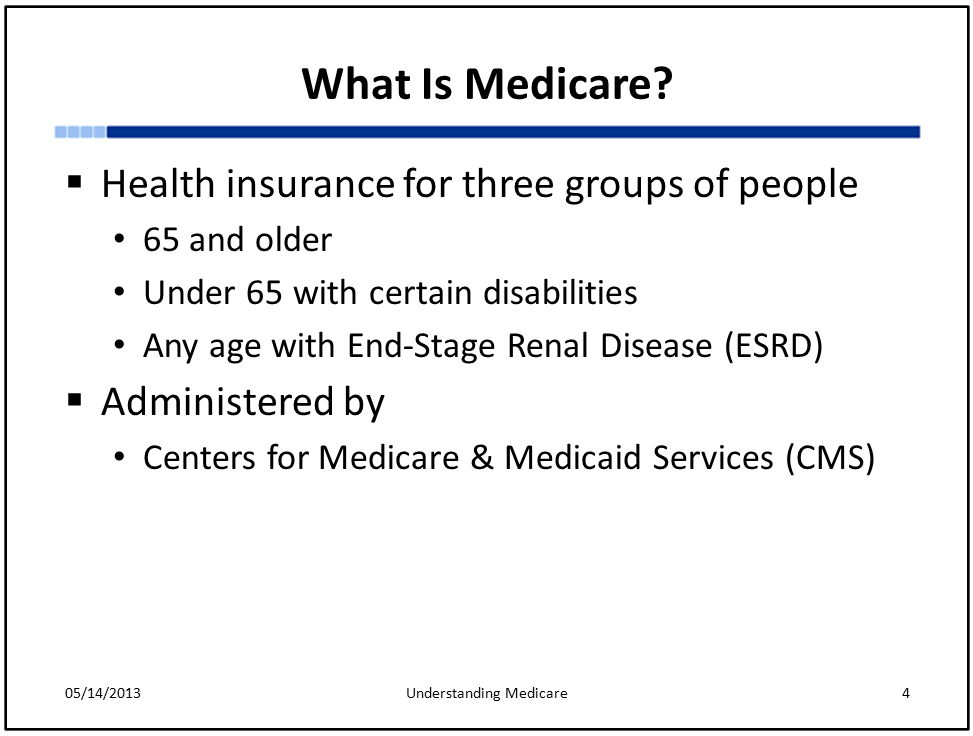
- Recognize the parts of Medicare;
- Compare Medicare coverage options;
- Understand Medicare-covered services and supplies;
- Recognize Medicare rights and appeals; and
- Explain programs for people with limited income and resources.



Lesson 1

Lesson 1, *Program Basics*, explains the following:

- What Medicare is;
- Enrolling in Medicare; and
- Part A and B benefits and costs.

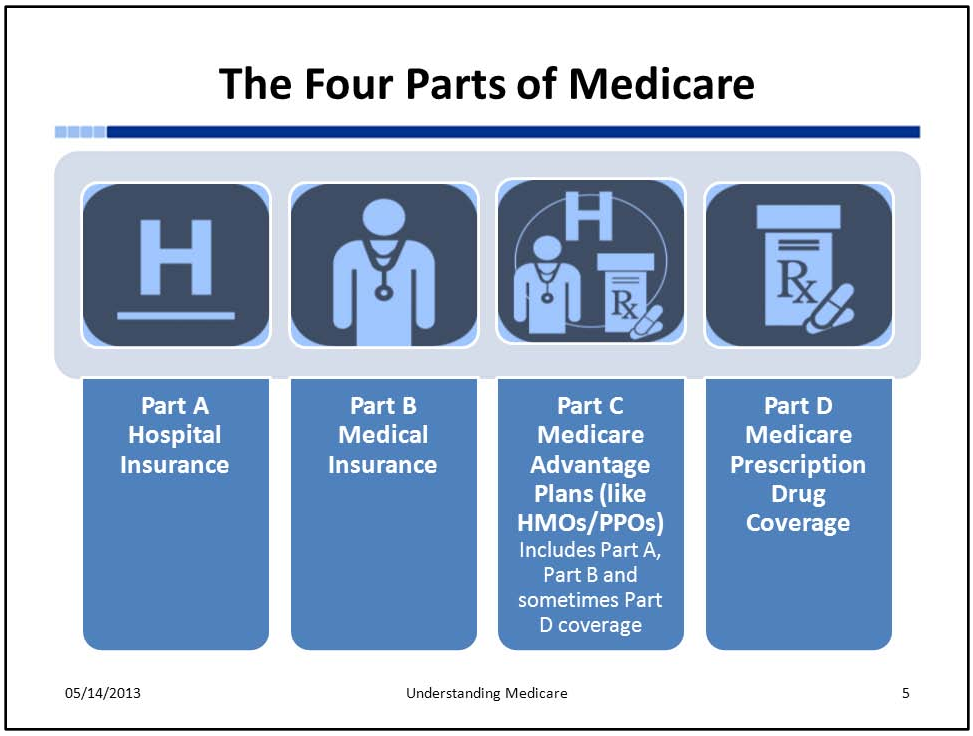


President Lyndon Johnson signed the Medicare and Medicaid programs into law on July 30, 1965. Medicare and Medicaid both became effective January 1, 1966. Medicare is the nation's largest health insurance program, currently covering about 52 million Americans.

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), which is permanent kidney failure requiring dialysis or a transplant.

CMS administers the Medicare program.



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

- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility (SNF) care, home health care, hospice care, and blood.
- **Part B (Medical Insurance)** helps cover medically necessary services like doctor's visits and outpatient care. Part B also covers many preventive services (including screening tests and shots), diagnostic tests, some therapies, and durable medical equipment (DME) 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 (MA) 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.

Automatic Enrollment – Part A and B

- Automatic for those receiving
  - Social Security benefits
  - Railroad Retirement Board benefits
- Initial Enrollment Period package
  - Mailed 3 months before
    - Age 65
    - 25th month of disability benefits
- Others must enroll themselves

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In most cases, if you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you'll 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'll 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. If you have ALS (Lou Gehrig's Disease), you'll automatically get Part A and Part B the month your disability benefits begin.

You'll 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.

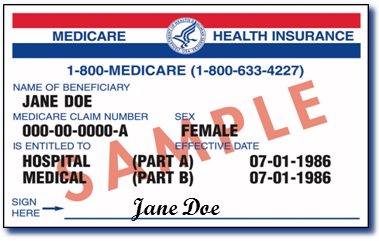
If you're not getting retirement benefits from Social Security or the RRB, you must enroll yourself to get Medicare. We'll talk about the periods when you can enroll later.

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



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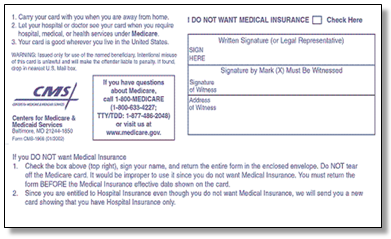

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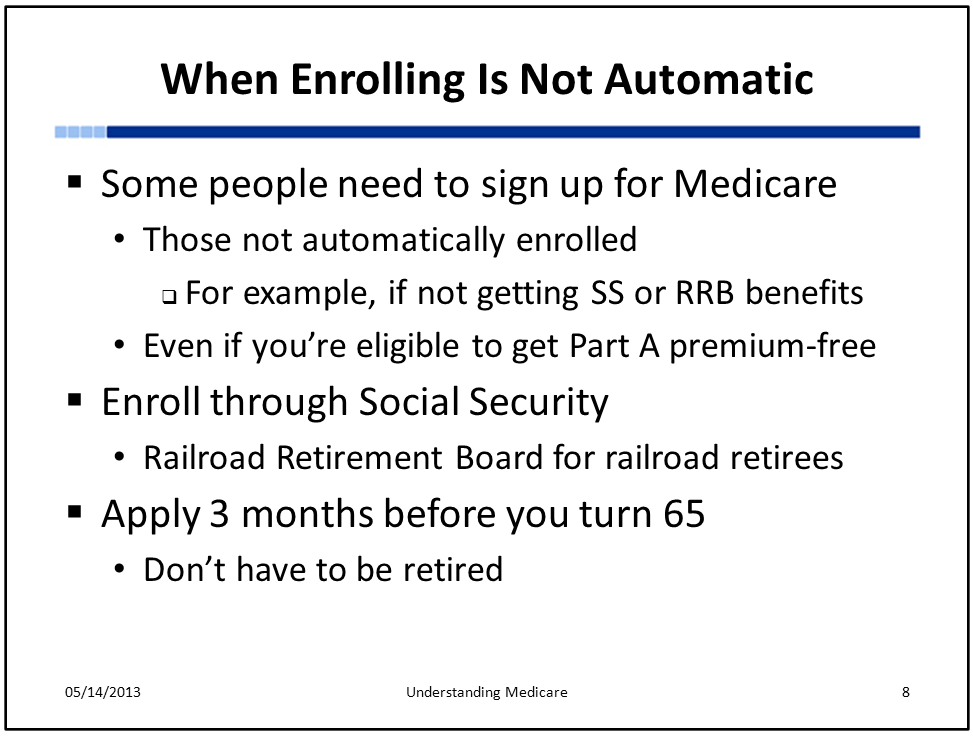
When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care services. The Medicare card shows the Medicare coverage (Part A and/or Part B) and the date the coverage starts. Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has nine numerals and one letter. There also may be a number or another letter after the first letter. The nine numerals show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you're 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. 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'll talk more about why you might want to delay Part B.

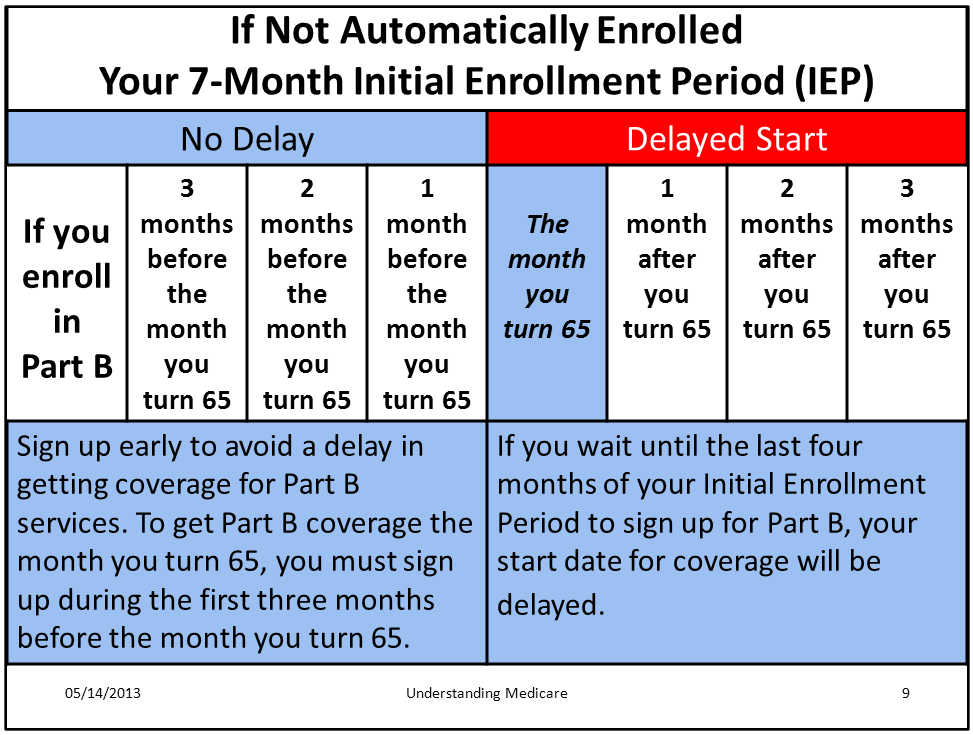
If you choose another type of Medicare health plan, your plan may give you a card to use when you get health care services and supplies.



If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits (for instance, because you are still working), you'll 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 65. If you worked for a railroad, contact the RRB to sign up.

While Medicare is administered by 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 don't 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; you can still receive full Medicare benefits at age 65.



If Not Automatically Enrolled
Your 7-Month Initial Enrollment Period (IEP)

	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.			

If you're not automatically enrolled, you can choose to sign up for Medicare during your Initial Enrollment Period (IEP). You can sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

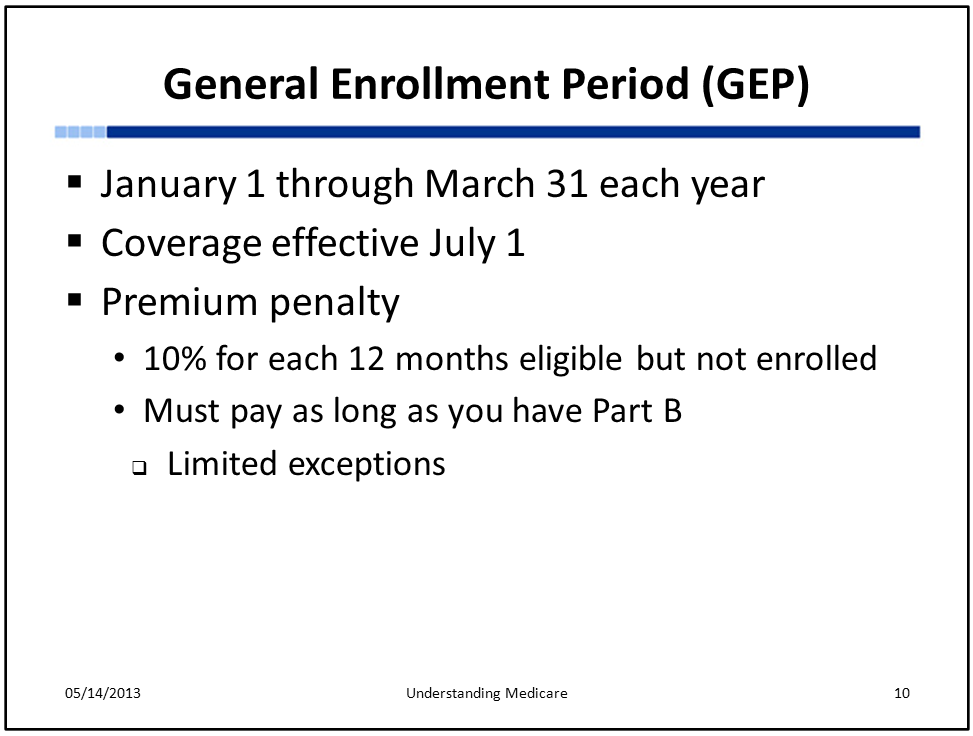
If you sign up for Part A and/or Part B during the first 3 months of your IEP, your coverage start date will depend on your birthday:

- If your birthday isn't on the first day of the month, your Part B coverage starts the first day of your birthday month. For example, Mr. Green's 65th birthday is July 20, 2013. If he enrolls in April, May, or June, his coverage will start on July 1, 2013.
- If your birthday is on the first day of the month, your coverage will start the first day of the prior month. For example, Mr. Kim's 65th birthday is July 1, 2013. If he enrolls in March, April, or May, his coverage will start on June 1, 2013. To read the chart above correctly, use the month before your birthday as "the month you turn 65."

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your IEP, your start date will be delayed. Coverage begins on the first day of

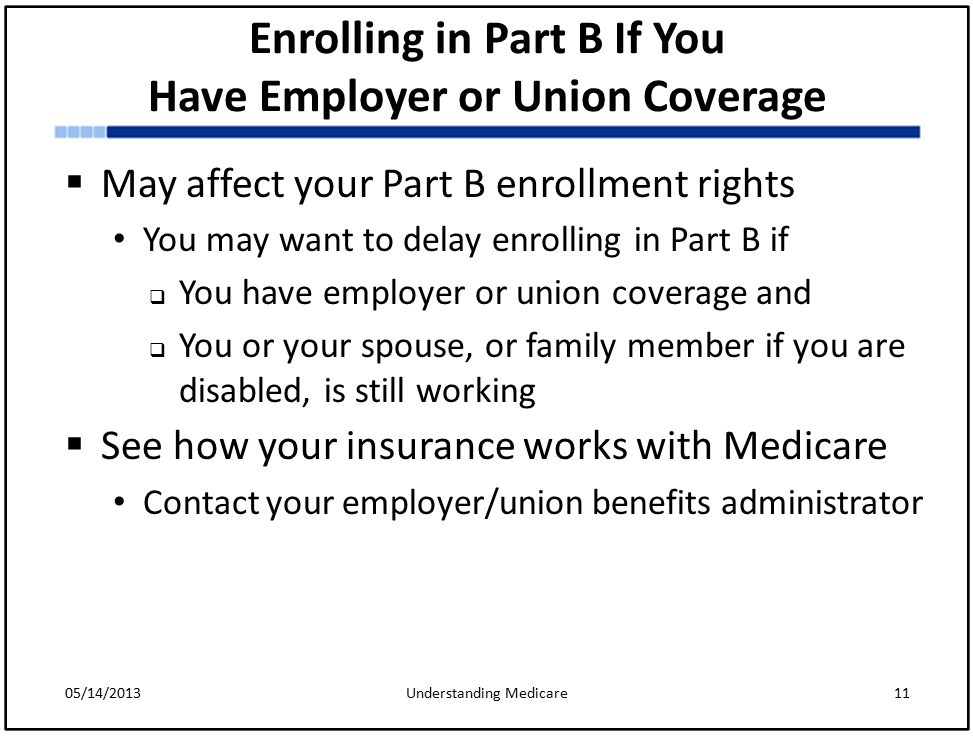
- The month following the month of enrollment if enrollment occurs during the fourth month of the IEP (the month you turn 65);
- The second month following the month of enrollment if enrollment occurs during the fifth month of the IEP; or
- The third month following the month of enrollment if enrollment occurs during the sixth or seventh month of the IEP.

You can choose whether or not to enroll in Part B. If you enroll, you pay a monthly premium for Medicare Part B.

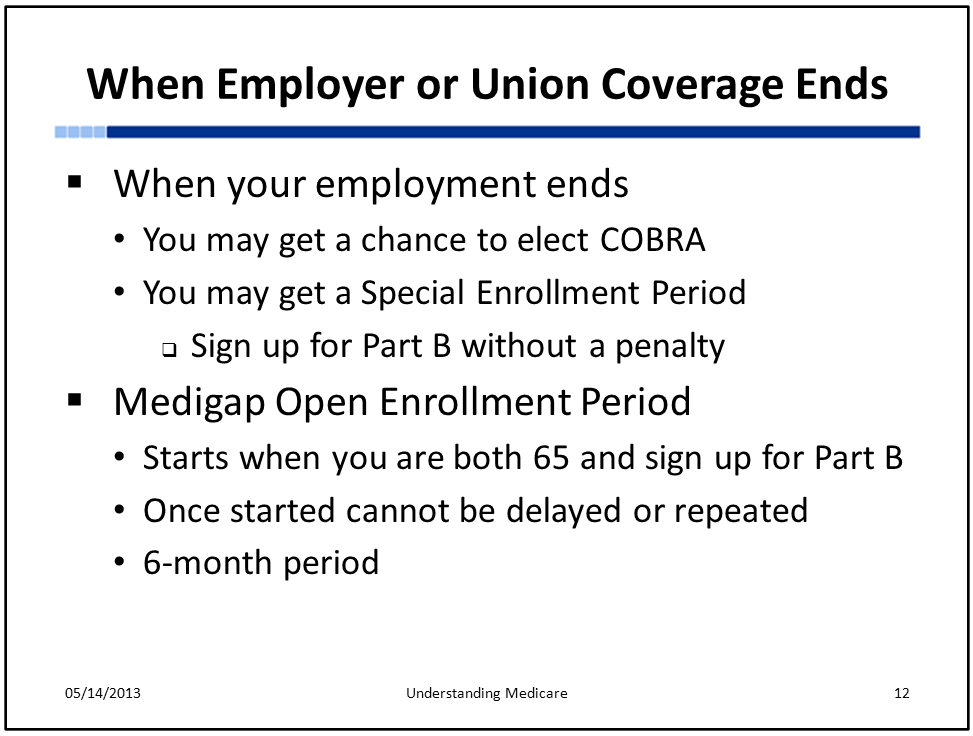


If you didn't sign up for Part A and/or Part B when you were first eligible, you can sign up between January 1 and March 31 each year. Your coverage will begin July 1. You may have to pay a higher Part A and/or Part B premium for late enrollment.

If you don't take Part B when you are first eligible, you'll have to pay a premium penalty of 10 percent 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'll have to pay this penalty for as long as you have Part B.



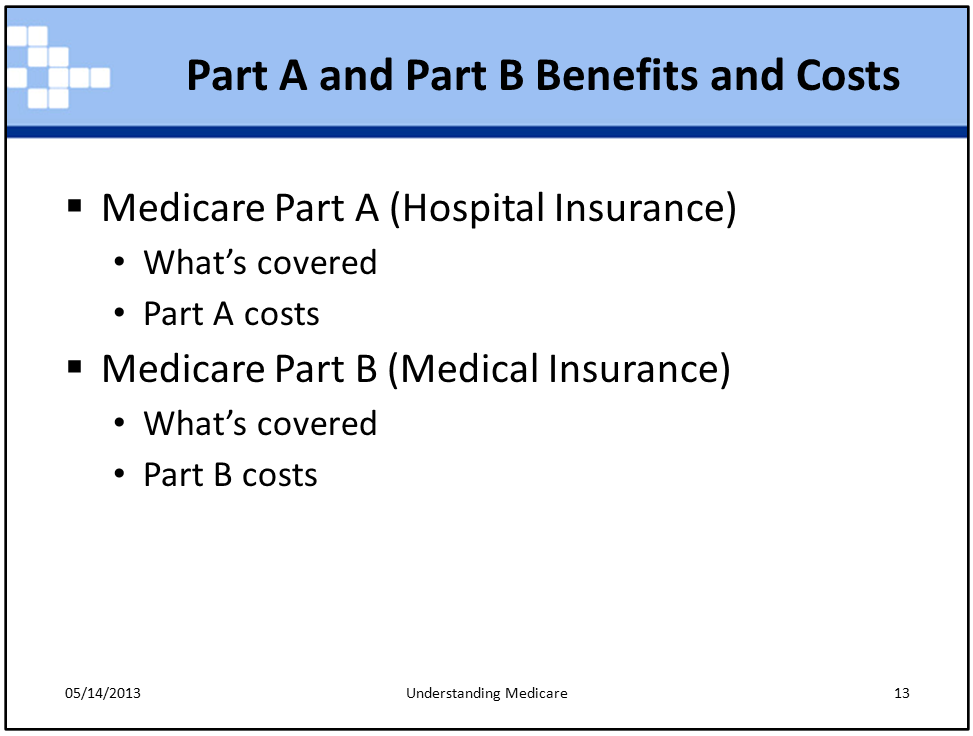
If you or your spouse (or family member if you're disabled) is still working and you have health coverage through that employer or union, contact your employer or union benefits administrator to find out how your coverage works with Medicare. This includes federal or state employment, but not military service. It may 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:

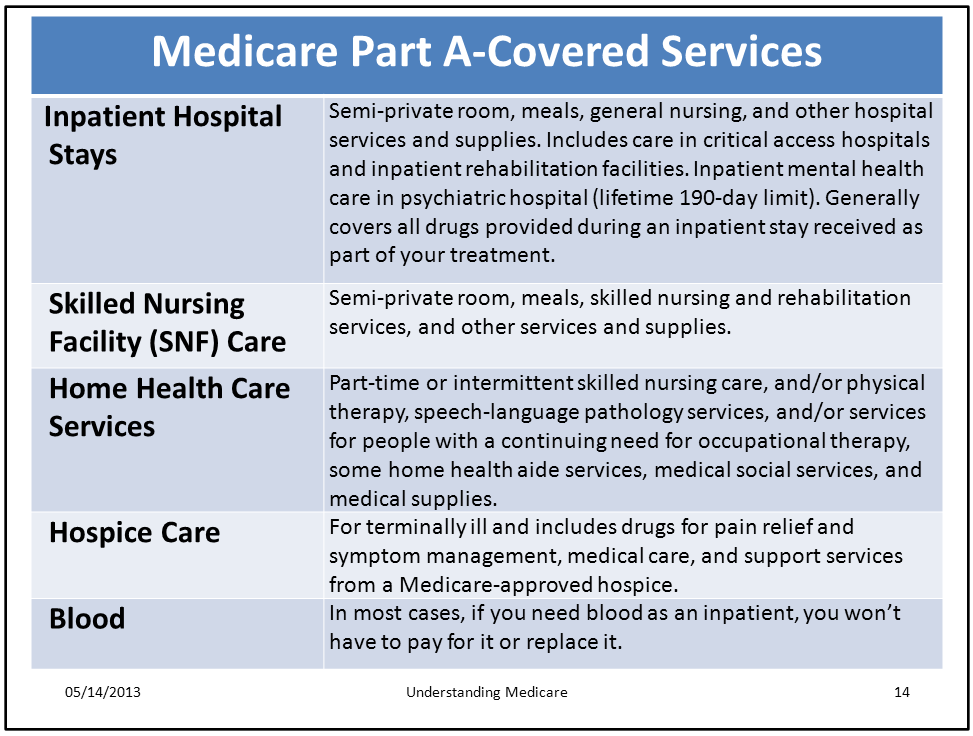
- You may get a chance to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
- You may get a Special Enrollment Period (SEP) to sign up for Part 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 SEP, you may have to pay a late enrollment penalty and you'll have to wait until the next General Enrollment Period (GEP) to enroll.

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



Part A and Part B benefits and costs explains the following:

- Medicare Part A:
  - What's covered; and
  - Part A costs.
- Medicare Part B:
  - What's covered; and
  - Part B 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 (SNF) Care	Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
Home Health Care Services	Part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with 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 for pain relief and symptom management, 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 the following when medically necessary:

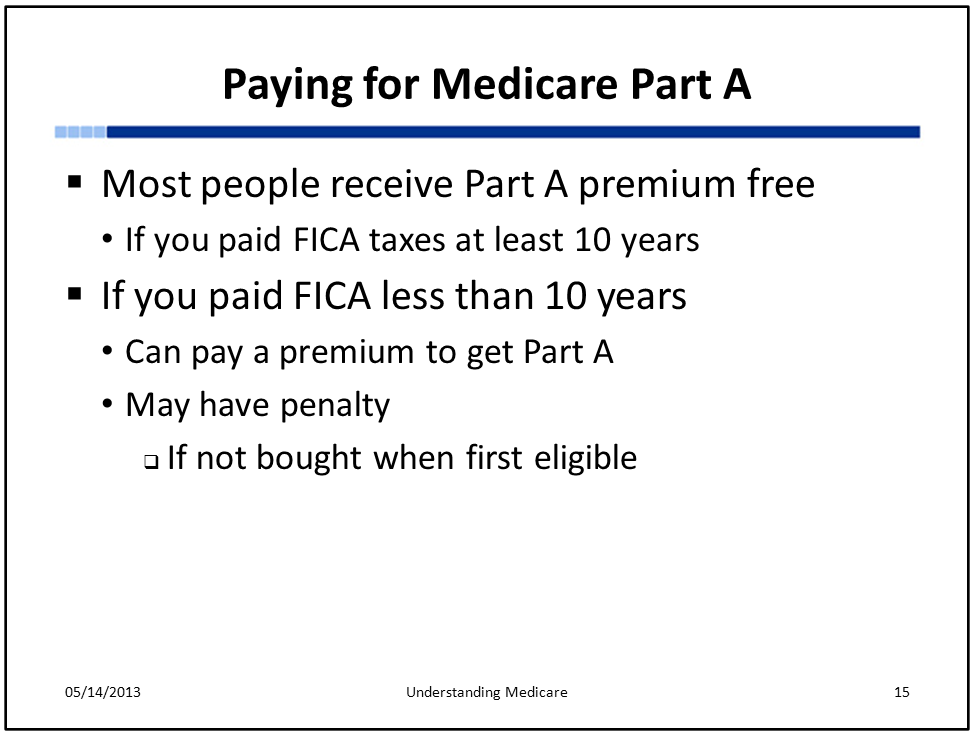
Hospital inpatient care — Covers semi-private room, meals, general nursing, and other hospital services and supplies; care in critical access hospitals and inpatient rehabilitation facilities; and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit). Coverage does not include 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, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face 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. Home health services may also include medical social services, part-time or intermittent home health aide services, DME, and medical supplies for use at home. You must be homebound, which means leaving home is a major effort.

Hospice care — For people with a terminal illness. Your doctor must certify that you are expected to live 6 months or less. Certification can be extended for 6-month periods. 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 and respite care.

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



You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A.

If you aren't eligible for premium-free Part A, you may be able to buy Part A if

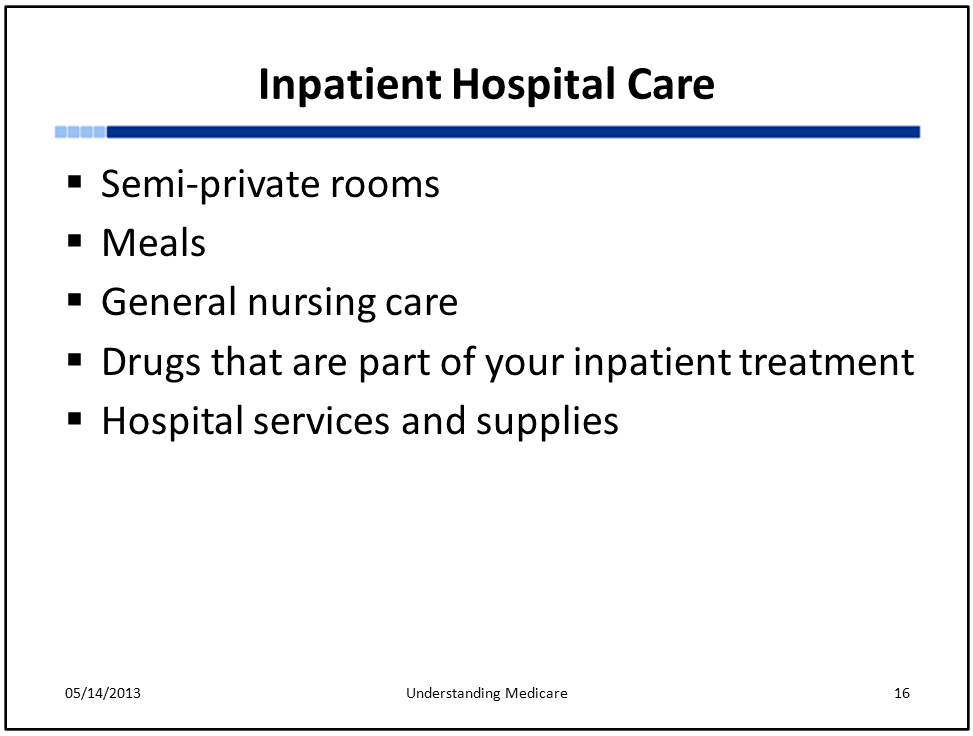
- You're 65 or older, and you have (or are enrolling in) Part B and meet the citizenship and residency requirements; or
- You're under 65, disabled, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and disabled, you can continue to get premium-free Part A for up to 8 1/2 years after you return to work.)

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

If you've worked less than 30 quarters of Medicare -covered employment, your Part A premium will be $441 per month (in 2013). If you've worked 30-39 quarters your Part A premium will be 45 percent of that amount, or $243 per month (in 2013). Social Security determines if you have to pay a monthly premium for Part A.

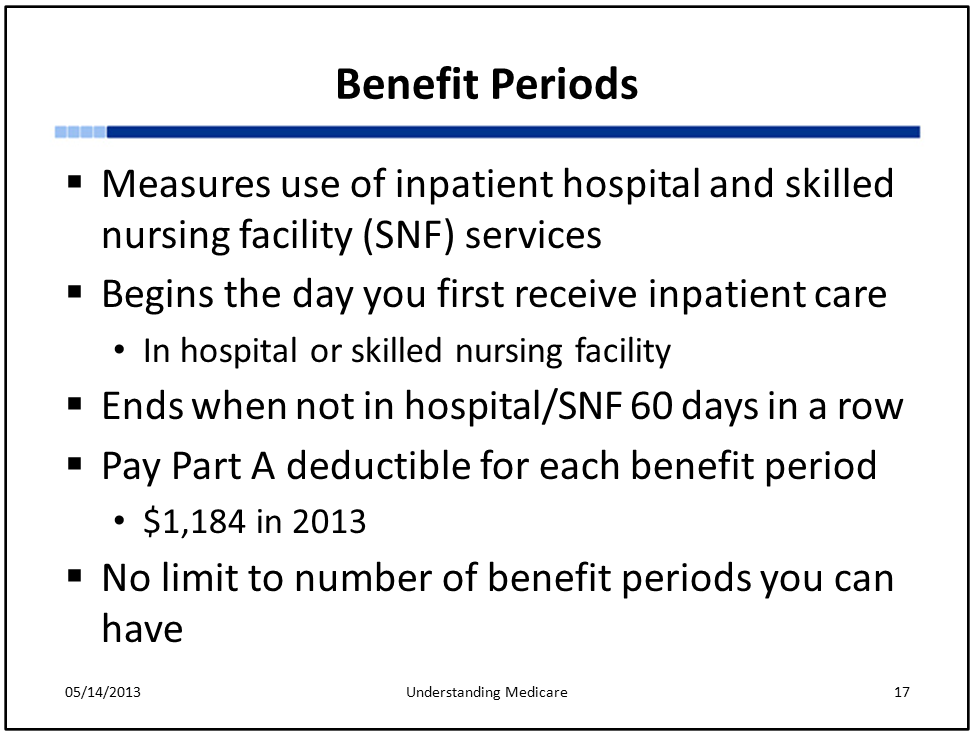
If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10 percent. You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up.

If you have limited income and resources, your state may help you pay for Part A and/or Part B. Call Social Security at 1-800-772–1213 for more information about the Part A premium. Teletype (TTY) users should call 1-800-325-0778.



Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.

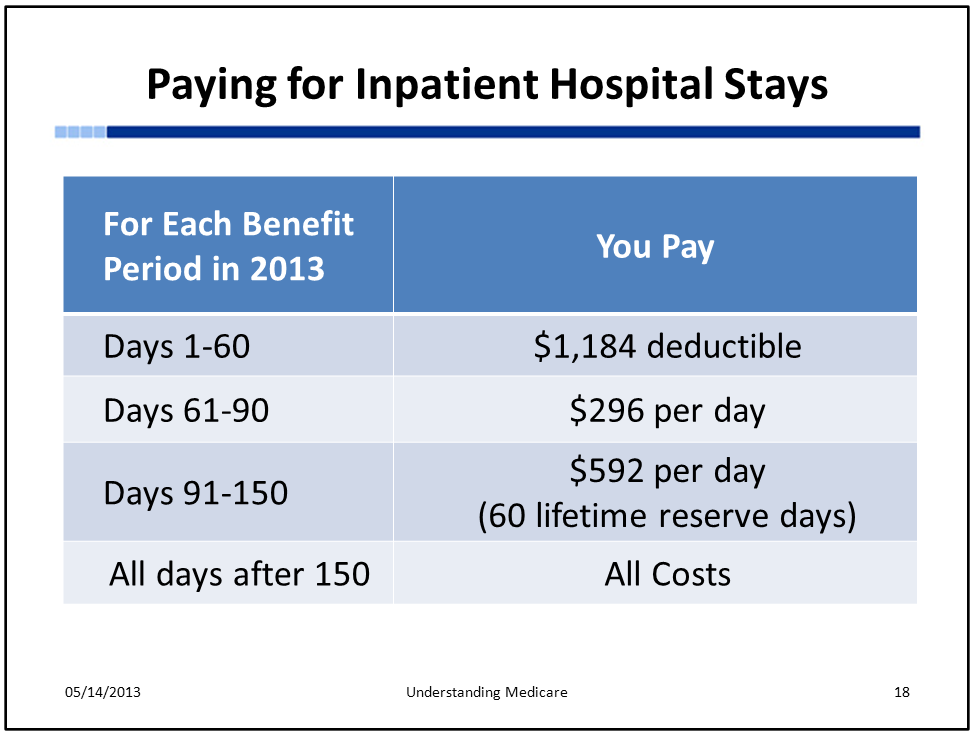
NOTE: Staying overnight in a hospital doesn't always mean you're an inpatient. You're considered an inpatient the day a doctor formally admits you to a hospital with a doctor's order. Always ask if you're an inpatient or an outpatient since it affects what you pay and whether you'll qualify for Part A coverage in a Skilled Nursing Facility (SNF).



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 SNF.

The benefit period ends when you are not in a hospital, or receiving skilled nursing care in an SNF, 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 ($1,184 in 2013) for each benefit period. There is no limit to the number of benefit periods you can have.



For each benefit period in 2013, you pay the following:

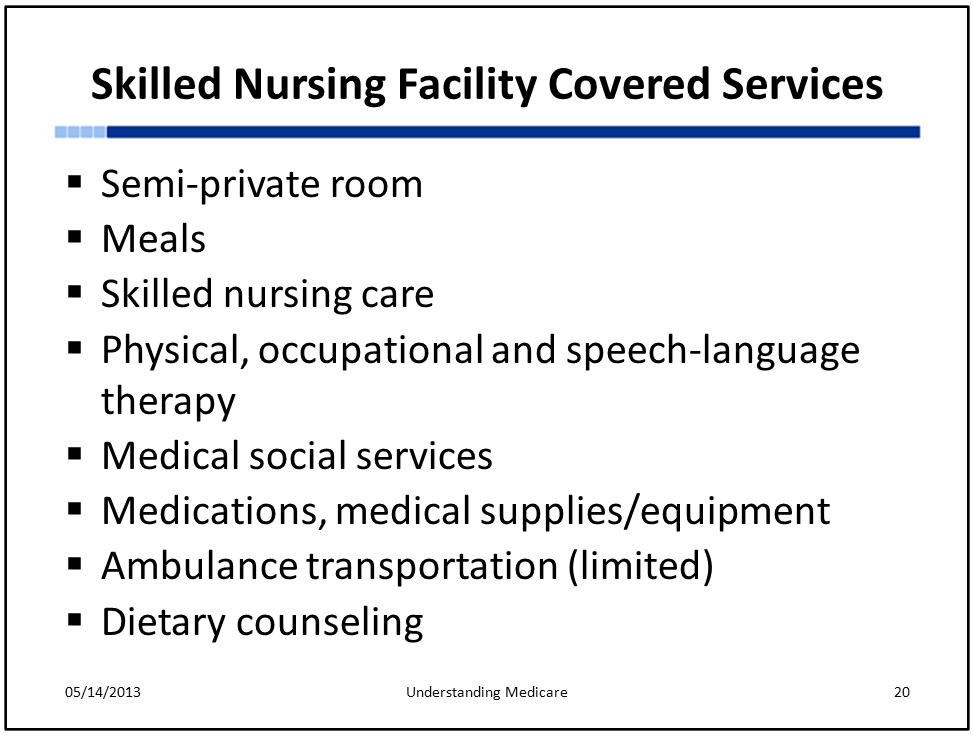
- You pay $1,184 and no copayment for days 1–60 each benefit period.
- You pay $296 for days 61–90 each benefit period.
- You pay $592 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).
  - Original Medicare will pay for 60 extra days (called lifetime reserve days) when you are in the 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.
- You pay all costs for each day after the lifetime reserve days.

NOTE: Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Part A will pay for Skilled Nursing Facility (SNF) care if you meet the following conditions:

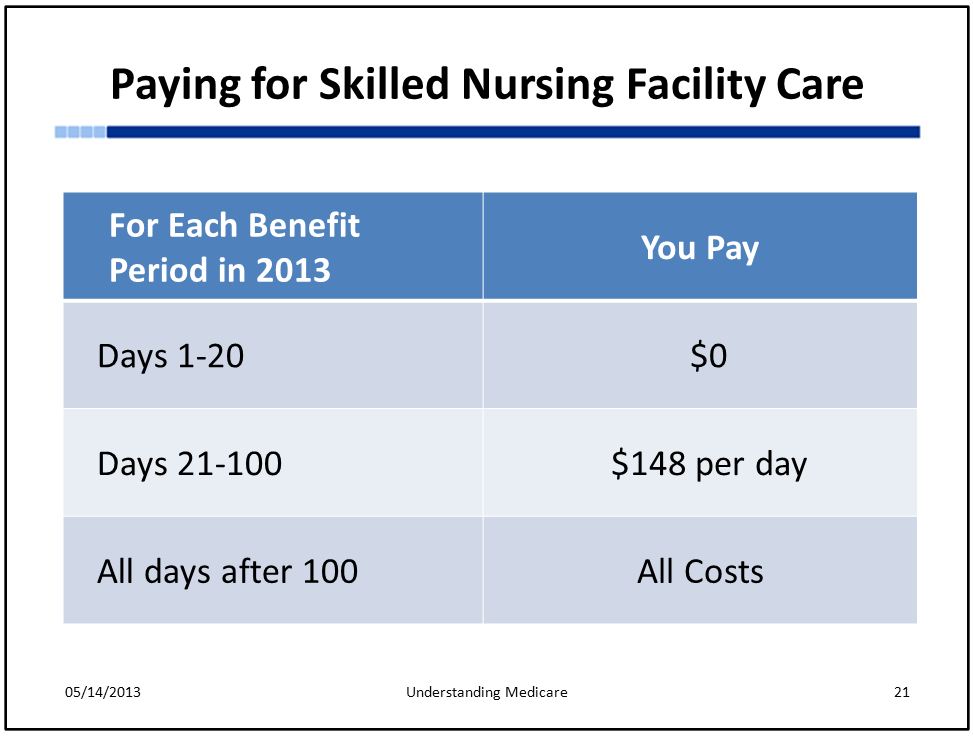
- Your condition requires daily skilled nursing or skilled rehabilitation services that can only be provided in an SNF.
  - This does not include custodial or long-term care. Medicare doesn't cover custodial care if it's the only kind of care you need. Custodial care is care that helps you with usual 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 3 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're an inpatient. An inpatient hospital stay begins the day you're 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 a hospital-treated condition.

The facility must be a Medicare participating SNF.



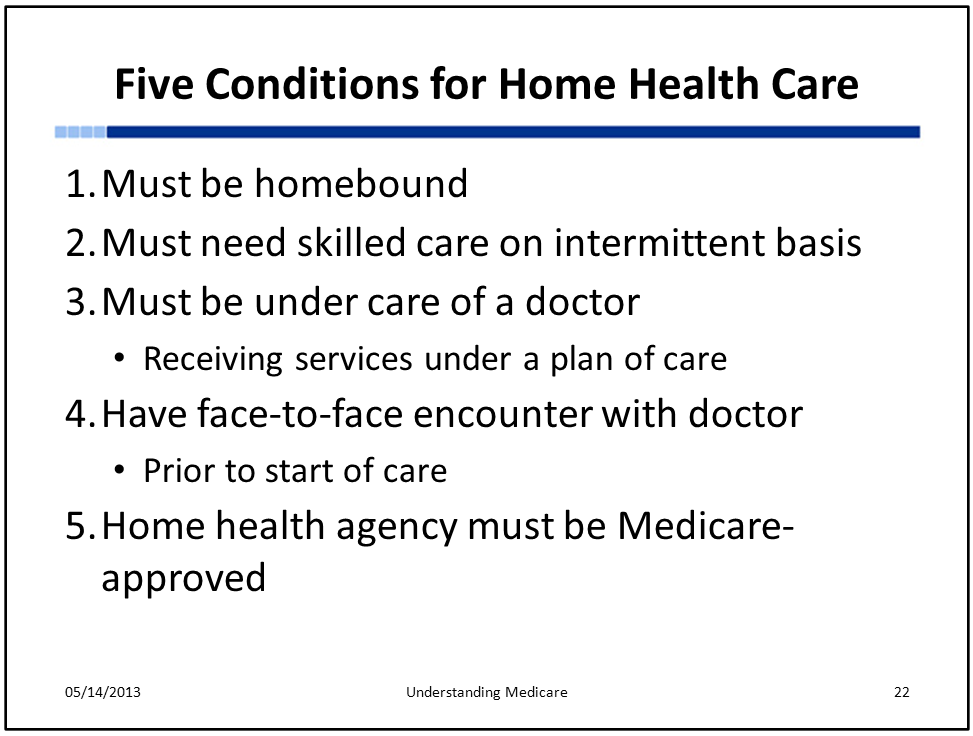
If you qualify, Medicare will cover the following Skilled Nursing Facility (SNF) services:

- 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 aren't available at the SNF when other transportation endangers health; and
- 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 2013, under Original Medicare, days 21 through 100 of SNF care are covered for each benefit period except for coinsurance of up to $148 per day. After 100 days, Medicare Part A no longer covers SNF care.

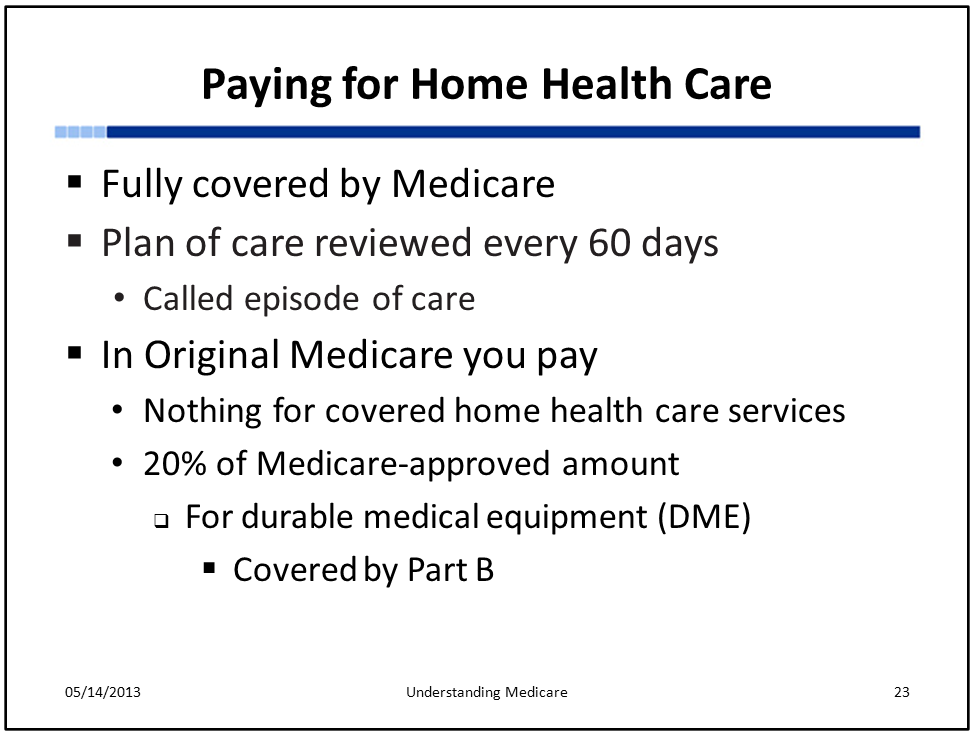
You can qualify for skilled nursing care again every time you have a new benefit period.



To be eligible for home health care services, you must meet all of these conditions:

1. You must be homebound, which means that you're 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. You can still get home health care if you attend adult day care, but you would get the home care services in your home.
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 your 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 you.
   - The encounter must be done up to 90 days prior, or within 30 days after the start of care.
   - The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site. This means medical or other health services given to a patient using a communications system (like a computer, phone, or television) by a practitioner in a location different than the patient's.
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 the need for home health care, or when the number of Part A–covered home health care visits exceeds 100.

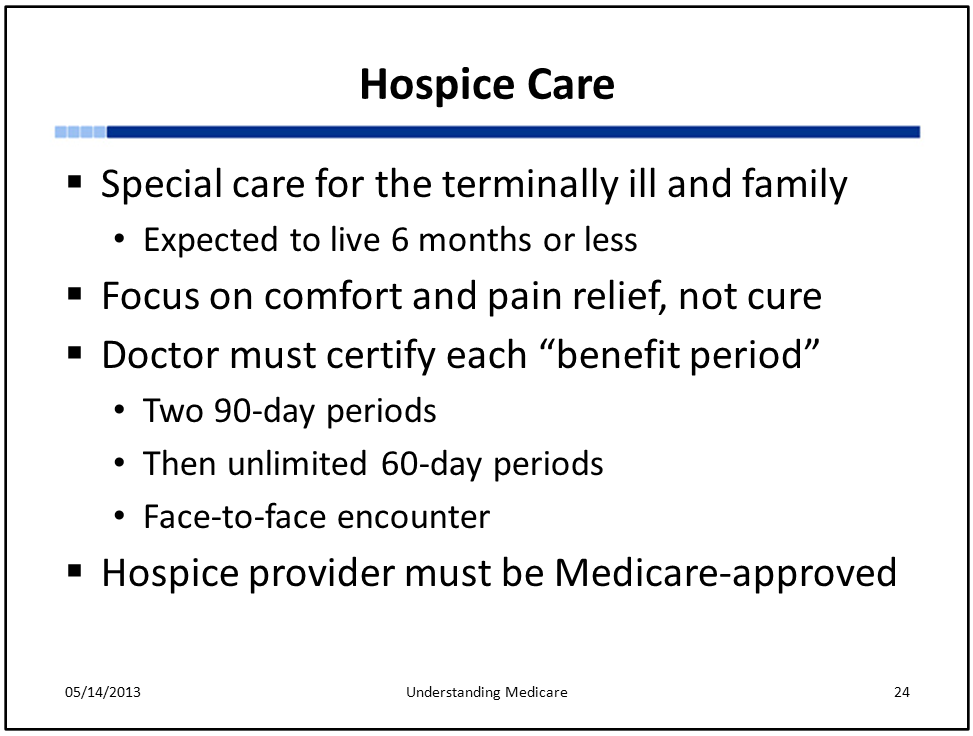


In Original Medicare, for Part A covered home health care, you pay:

- Nothing for covered home health care services provided by a Medicare-approved home health agency; and
- If you have Part B, you pay 20 percent of the Medicare-approved amount for an assigned DME claim. If the claim is non-assigned, you're responsible for whatever the DME supplier charges over and above the Medicare-approved amount. (We'll discuss assignment later.)

To find a home health agency in your area, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov and use the Home Health Compare tool. TTY users should call 1-877-486-2048.

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 doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.



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

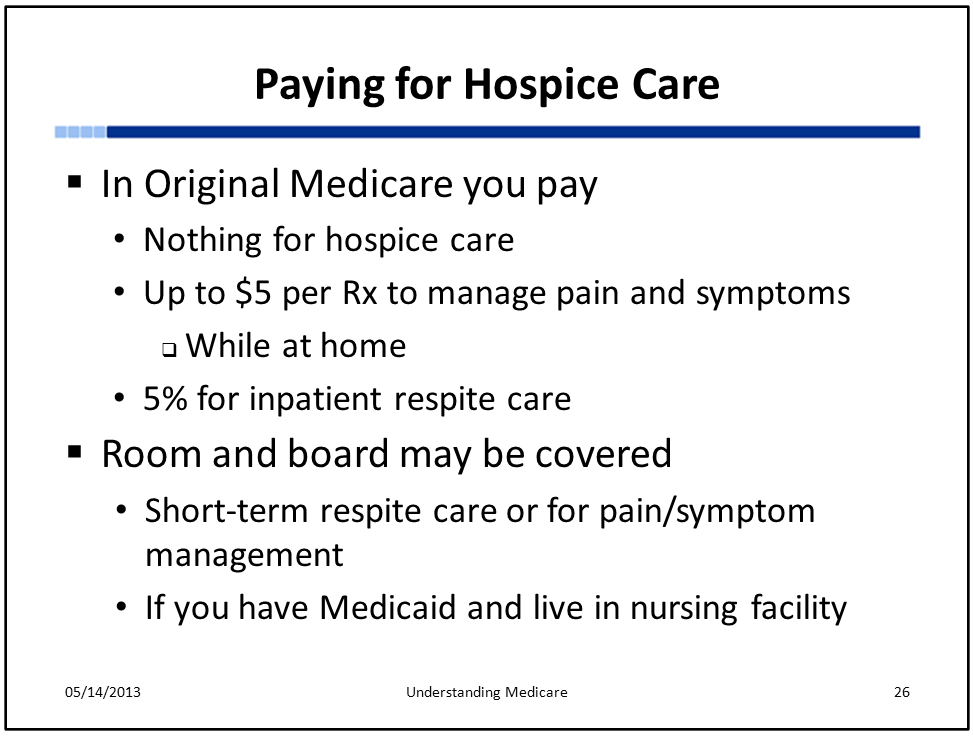
You can get hospice care as long as your doctor certifies that you are terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "benefit periods"—two 90-day periods followed by unlimited 60-day periods. At the start of each benefit period, your doctor must certify that you're terminally ill for you to continue getting hospice care.

Medicare recently added a new requirement for hospice face-to-face visits:

- Requires doctor meet with you within 30 days of hospice recertification;
- Starting before the third benefit period; and
- The hospice provider must be Medicare approved.

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 (SNF) when needed for pain and symptom management.
- Inpatient respite care, which is care given to you by another caregiver, so your usual caregiver can rest. You'll 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's 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.

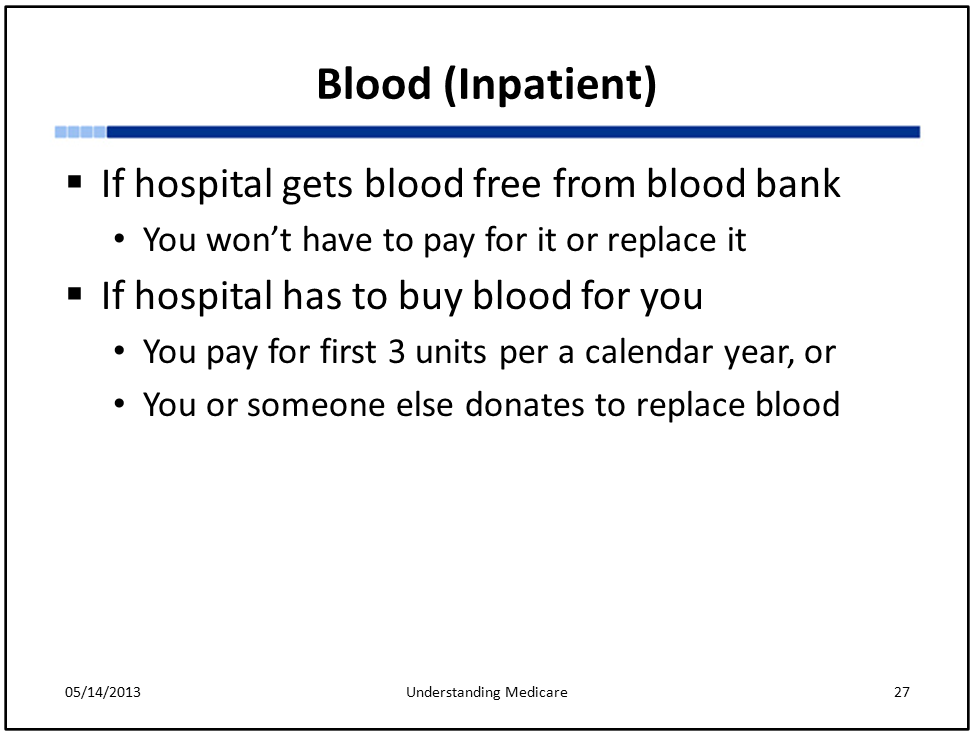


For hospice care in Original Medicare, you pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control, and 5 percent of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'll 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 aren't 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 a nursing facility, room and board are covered by Medicaid.

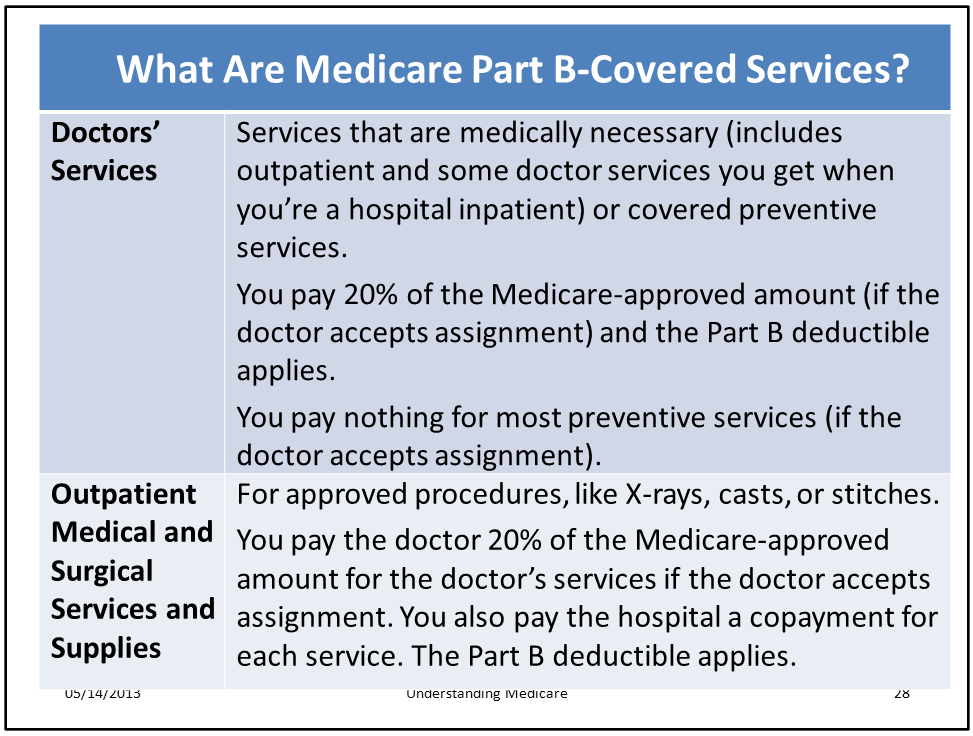
Need More Information?

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227) or your state hospice organization. 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 three units of blood you get in a calendar year, or have the blood replaced (donated) by you or someone else.



What Are Medicare Part B-Covered Services?

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. You pay 20% of the Medicare-approved amount (if the doctor accepts assignment) and the Part B deductible applies. You pay nothing for most preventive services (if the doctor accepts assignment).
Outpatient Medical and Surgical Services and Supplies	For approved procedures, like X-rays, casts, 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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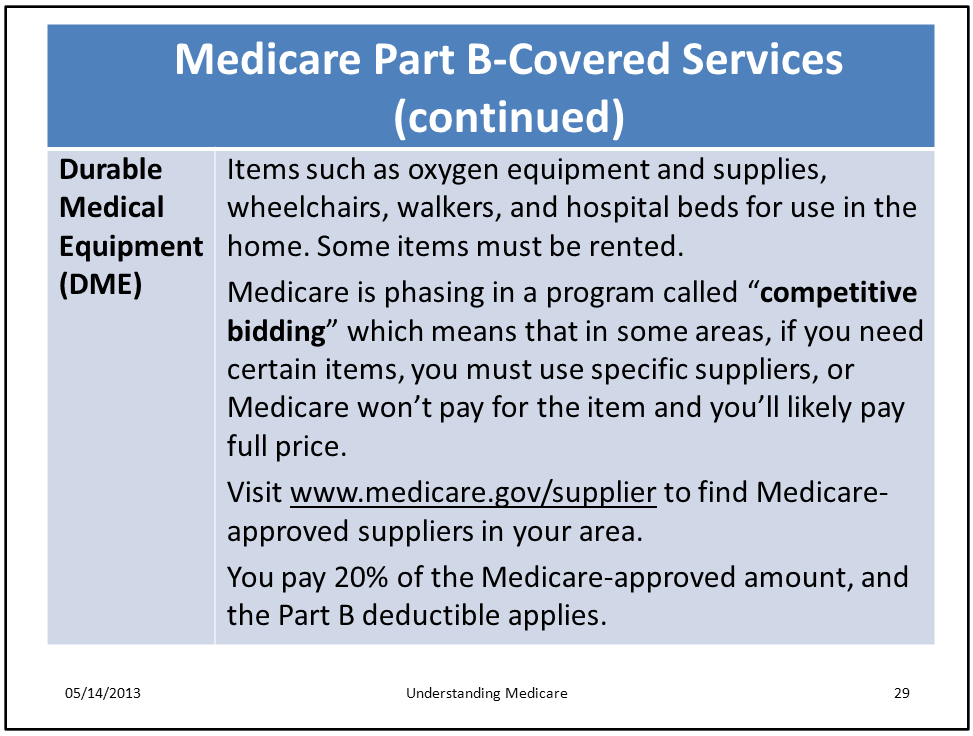
Medicare Part B covers a variety of medically necessary outpatient services and supplies. Certain requirements must be met.

Doctors' services — Medicare covers medically necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20 percent of the Medicare-approved amount, and the Part B deductible applies.

Outpatient medical and surgical services and supplies — Medicare covers approved procedures like X-rays, casts, or stitches. You pay 20 percent of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. The Part B deductible applies.

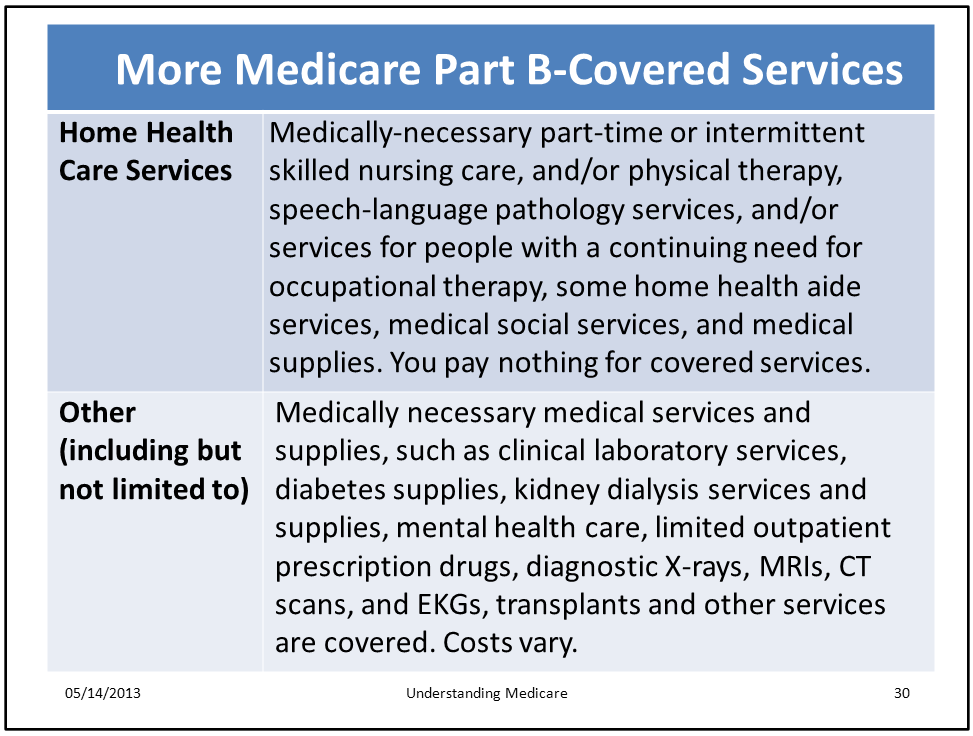


Durable Medical Equipment (DME) — Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20 percent of the Medicare-approved amount, 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.

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'll likely 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. The program is scheduled to expand to 91 more areas around the country in July 2013.

If you need DME or supplies, visit www.medicare.gov/supplier to find Medicare-approved suppliers. If your ZIP code is in a competitive bidding area, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

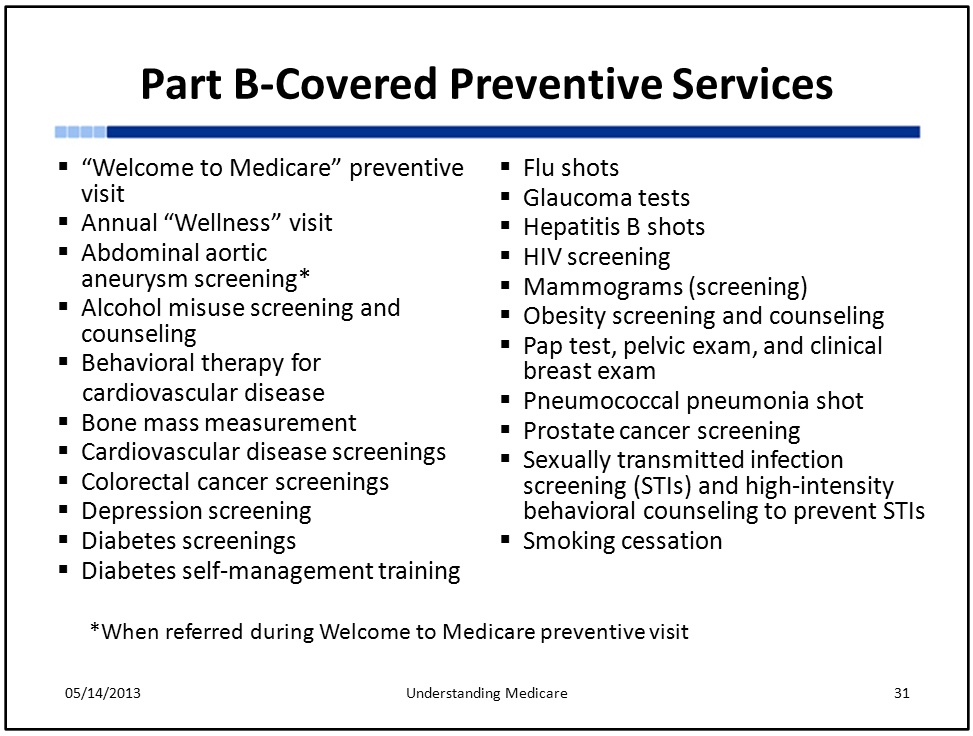
For more information on the competitive bidding program, you can visit: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.



Home health care services — Medicare covers medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face 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. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment (DME), and medical supplies for use at home. You must be homebound, which means leaving home is a major effort. You pay nothing for covered home health services.

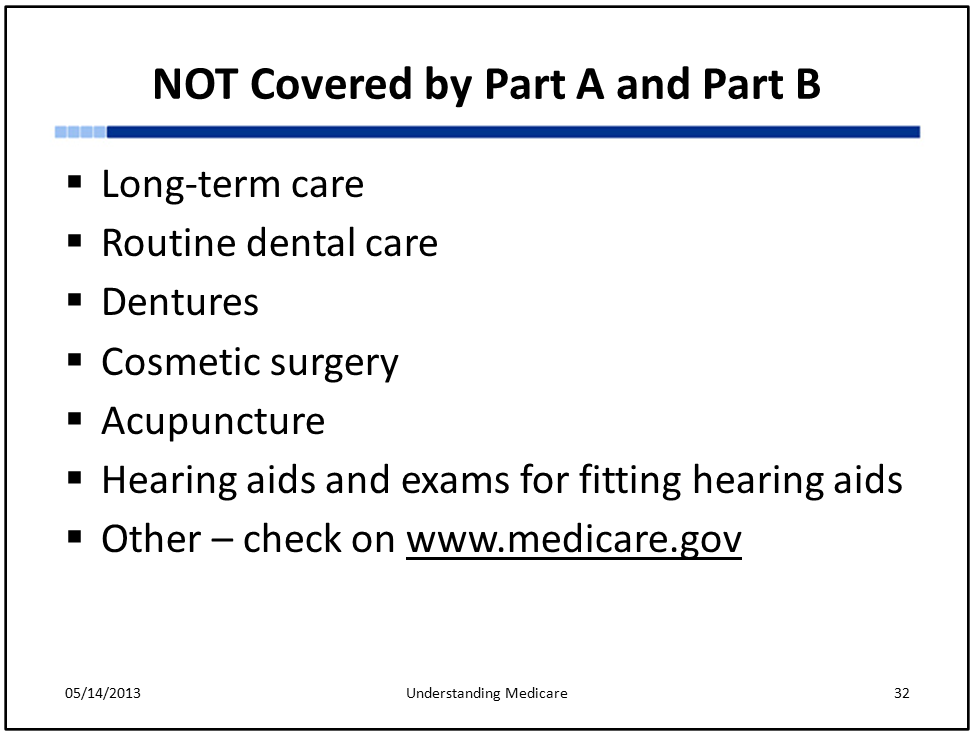
Other (including, but not limited to) — Medically necessary clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, EKGs, transplants, and other services are covered. Costs vary.

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're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.



Medicare Part B–covered preventive services include the following:

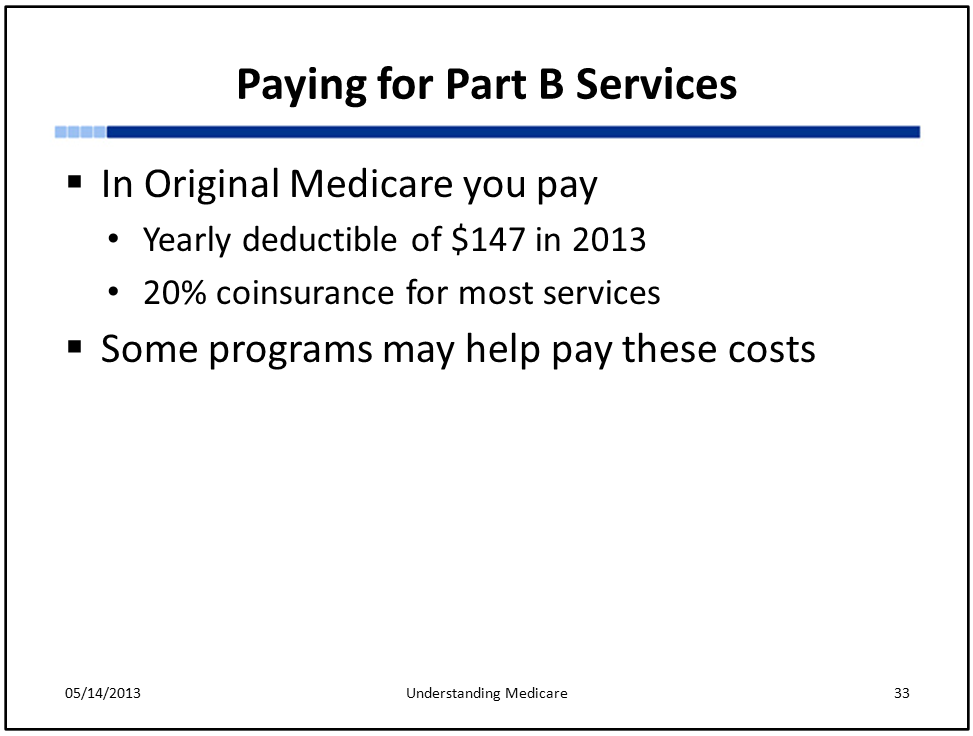
- "Welcome to Medicare" preventive visit
- Annual "Wellness" visit;
- Abdominal aortic aneurysm screening* (when referred during the "Welcome to Medicare" preventive visit);
- Alcohol misuse screening and counseling;
- Behavioral therapy for cardiovascular disease;
- Bone mass measurement;
- Cardiovascular 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, and clinical breast exam;
- Pneumococcal pneumonia shot;
- Prostate cancer screening;
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs; and
- Smoking cessation.



Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you'll 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.

*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.



Under Original Medicare, if the Part B deductible ($147 in 2013) applies you must pay all costs until you meet the yearly Part B deductible before Medicare begins to pay its share. Then, after your deductible is met, you typically pay 20 percent of the Medicare-approved amount of the service, if the doctor or other health care provider accepts assignment (see page 41). There's no yearly limit for what you pay out of pocket. You also pay some copayments or coinsurance for Part B services. The amount depends upon the service, but is 20 percent in most cases.

You pay nothing for most preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both.

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

Monthly Part B Premium

If Your Yearly Income in 2011 was		In 2013 You Pay
File Individual Tax Return	File Joint Tax Return	
$85,000 or less	$170,000 or less	$104.90
$85,000.01 – $107,000	$170,000.01 – $214,000	$146.90
$107,000.01 – $160,000	$214,000.01 – $320,000	$209.80
$160,000.01 – $214,000	$320,000.01 – $428,000	$272.70
Above $214,000	Above $428,000	$335.70
*per month		

Note: Premiums are usually deducted from your Social Security benefit payment.

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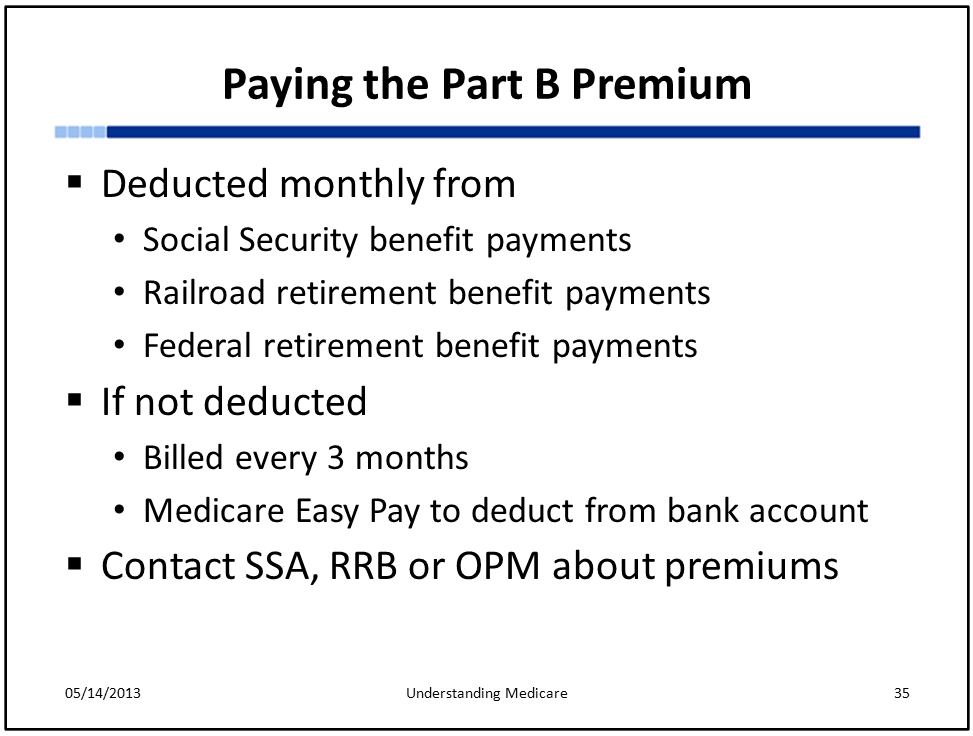
You pay the Part B premium each month. Most people will pay the standard premium amount, which is $104.90 in 2013. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you may pay more. Below are the 2013 Part B premiums based on the modified adjusted gross income for an individual. The income ranges for joint returns are double that of individual returns:

- $85,000 or less, the Part B premium is $104.90 per month;
- $85,000.01 - $107,000, the Part B premium is $146.90 per month;
- $107,000.01 - $160,000, the Part B premium is $209.80 per month;
- $160,000.01 - $214,000 the Part B premium is $272.70 per month; and
- Above $214,000, the Part B premium is $335.70 per month.

If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Remember that this premium may be higher if you didn't choose Part B when you first became eligible. The cost of Part B may go up 10 percent for each 12-month period that you could have had Part B but didn't take it. An exception would be if you or your spouse (or family member if you're disabled) is still employed and you're covered by a group health plan through that employment. In that case, you're eligible to enroll in Part B during a SEP and you won't pay a penalty.

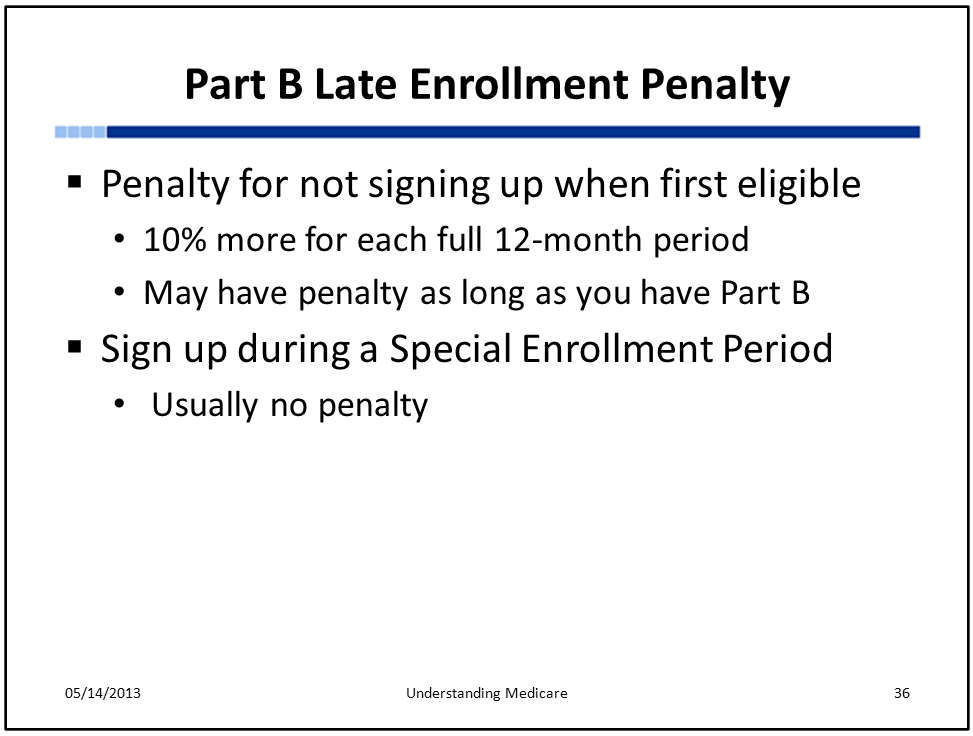


The Part B premium is deducted from monthly Social Security, Railroad Retirement, or federal retirement benefit payments.

If you don't get a retirement payment or your payment isn't enough to cover the premium, you'll get a bill from Medicare for your Part B premium. The bill can be paid by credit card, check, or money order.

For information about Medicare Part B premiums, call the Social Security Administration (SSA), Railroad Retirement Board (RRB), or the Office of Personnel Management (OPM) for retired federal employees.

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

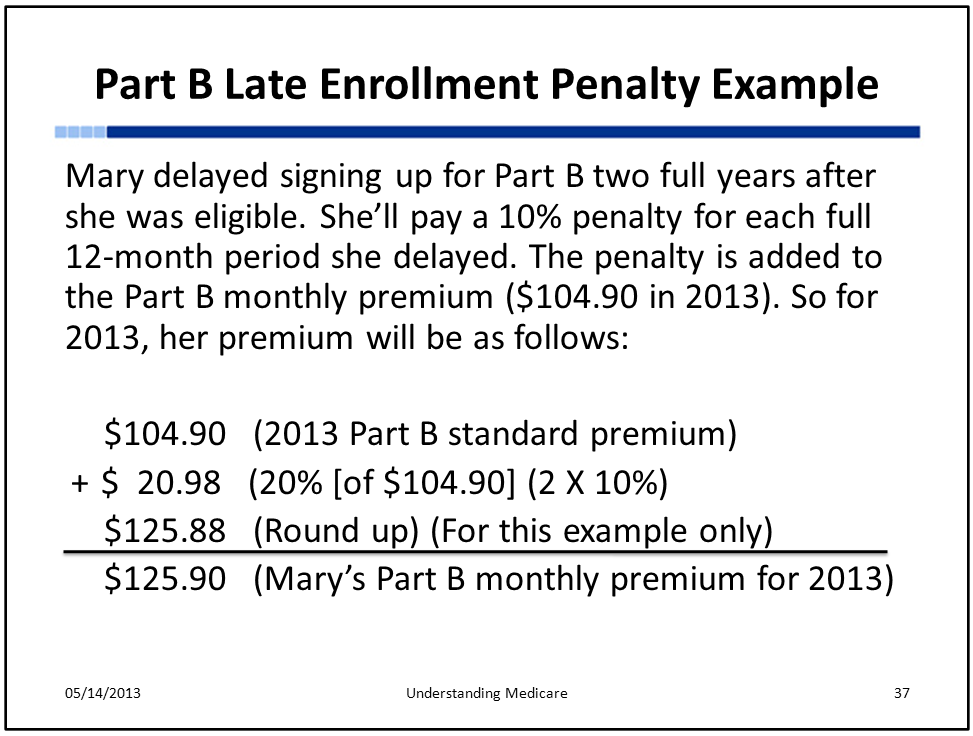


If you don't take Part B when you're first eligible, you may have to wait to sign up during the annual General Enrollment Period (GEP), which runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.

If you don't take Part B when you're first eligible, you'll have to pay a premium penalty of 10 percent 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'll have to pay this penalty for as long as you have Part B.

Having coverage through an employer (including federal or state employment, but not military service) or union while you or your spouse (or family member if you're disabled) is still working can affect your Part B enrollment rights. If you're covered through active employment (yours or your spouses), you have an SEP. This means you can join Part B anytime that you or your spouse (or family member if you're disabled) is working, and 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. Usually, you don't pay a late enrollment penalty if you sign up during an SEP. This SEP doesn't apply to people with ESRD.

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.



This is an example of how you might calculate a late enrollment penalty for Part B.

Mary delayed signing up for Part B 2 full years after she was eligible. She'll pay a 10 period penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium ($104.90 in 2013). So for 2013, her premium will be as follows:

$104.90 (2013 Part B standard premium)
\+ $20.98 (20% [of $104.90] (2 X 10%)
$125.88 (Round up) (For this example only)

$125.90 (Mary's Part B monthly premium for 2013)

Check Your Knowledge
Lesson 1 – Program Basics

Answer the following questions:

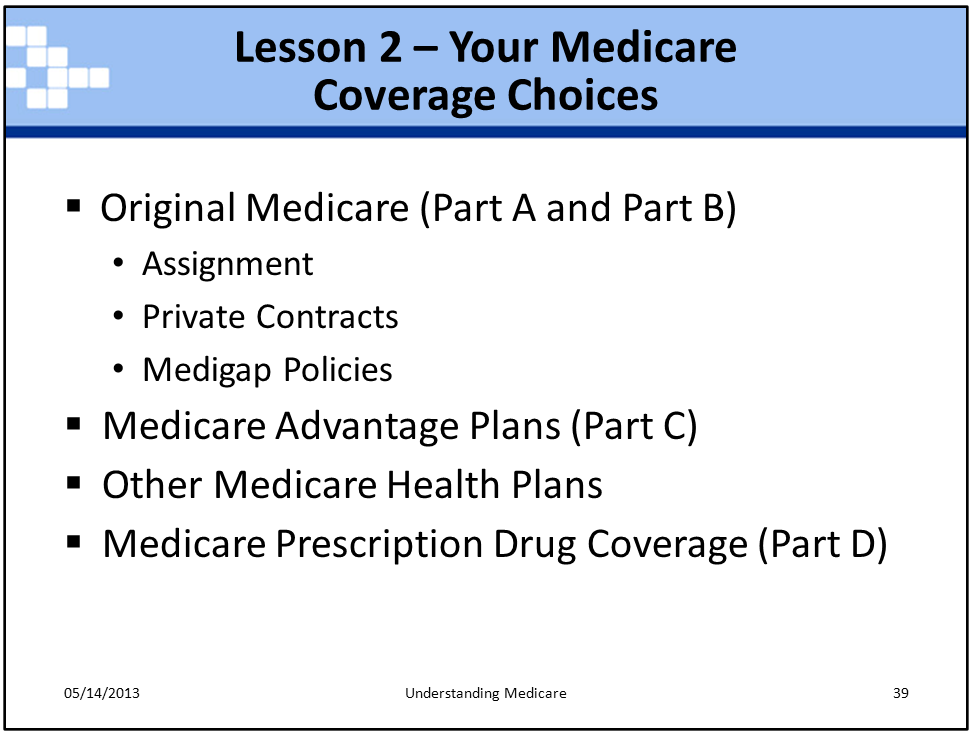
1. Medicare Part A helps pay for

    a. Inpatient hospital stays
    b. Skilled Nursing Facility (SNF) care
    c. Home health care
    d. All of the above

2. If you are under 65 and disabled, you'll automatically get Part A and Part B after you get disability benefits for

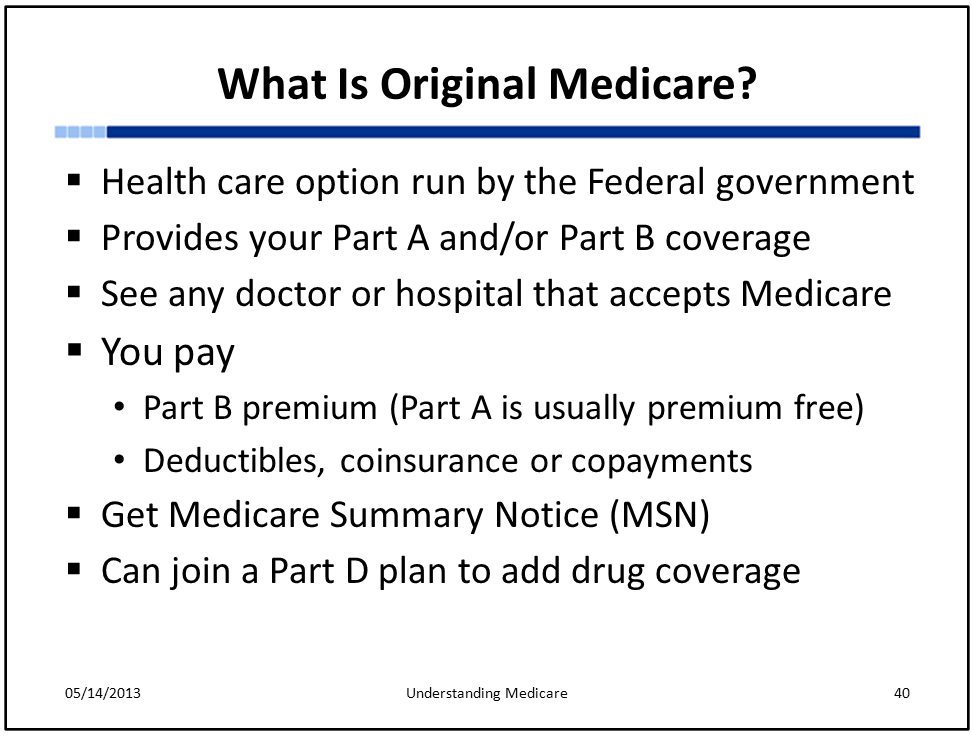
    a. 12 months
    b. 24 months
    c. 36 months
    d. It is not automatic, you must apply

Refer to page 99 to check your answers.



Lesson 2, *Your Medicare Coverage Choices*, explains

- Original Medicare (Part A and Part B):
  - Assignment;
  - Private contracts; and
  - Medigap policies.
- Medicare Advantage (MA) – also known as Part C;
- Other Medicare Health Plans; and
- Medicare Prescription Drug Coverage (Part D).

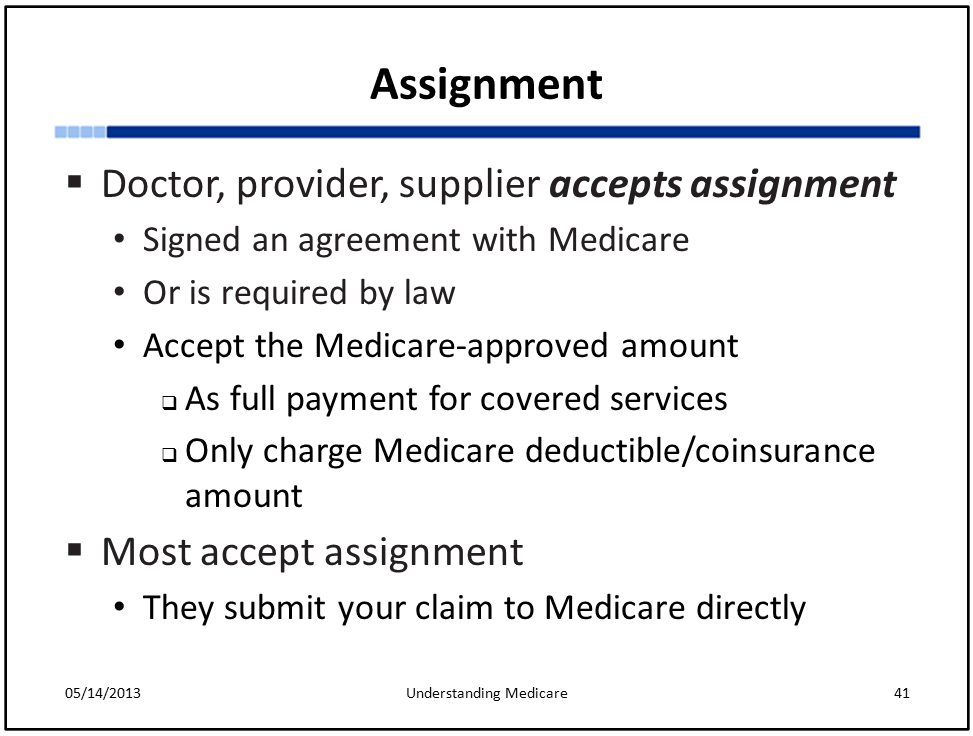


Original Medicare is one of the coverage choices in the Medicare program. You'll be in Original Medicare unless you choose to join a Medicare Advantage (MA) plan or other Medicare plan. Original Medicare is a fee-for-service program that is managed by the federal government. With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

If you have Medicare Part A, you get all medically necessary Part A–covered services. If you have Medicare Part B, you get all medically necessary Part B–covered services. As we mentioned earlier, Part A is premium-free for most people. For Medicare Part B you pay a monthly premium. The standard Medicare Part B monthly premium is $104.90 in 2013.

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's information on the MSN about how to ask for an appeal.

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



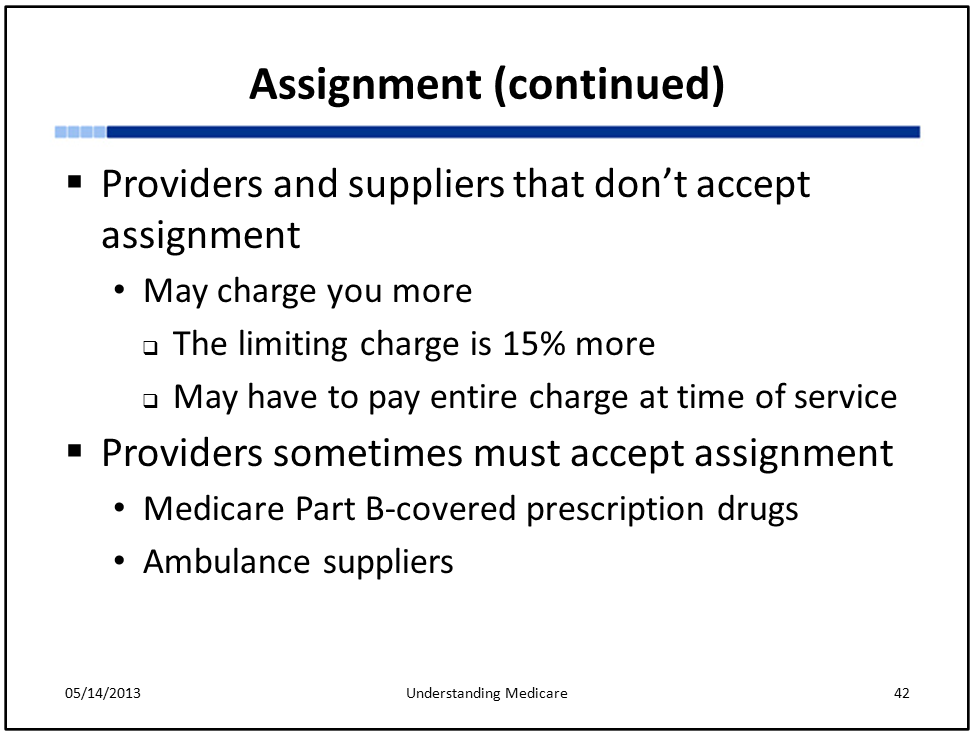
Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. Participating providers have signed an agreement to accept assignment for all Medicare-covered services.

Here's what happens if your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less;
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share; and
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

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.



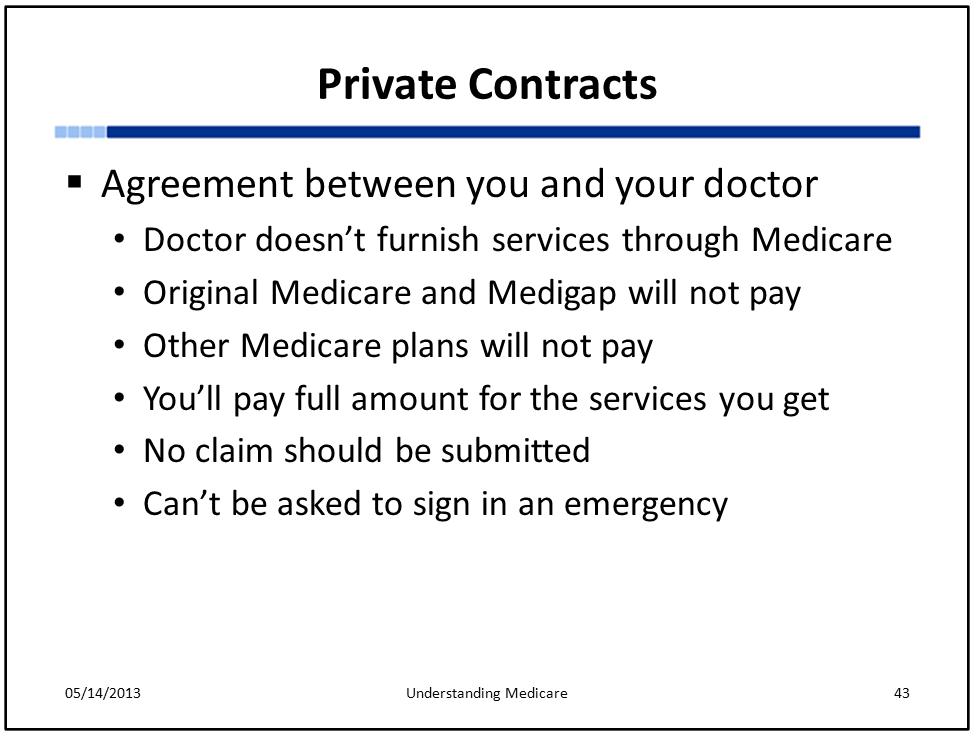
Non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. These providers are called "non-participating."

Here's what happens if your doctor, provider, or supplier **doesn't accept** assignment:

- You might have to pay the entire charge at the time of service. Your doctor, provider, or supplier is 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. In some cases, you might have to submit your own claim to Medicare using form CMS-1490S in order to be reimbursed. Visit http://medicare.gov/forms-help-and-resources/forms/medicare-forms.html for the form and instructions.
- They can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge" or "excess charge." The provider can only charge you up to 15 percent over the amount that non-participating providers are paid. Non-participating providers are paid 95 percent of the fee schedule amount. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment (DME).

To find out if your doctors, suppliers, and other health care providers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier.

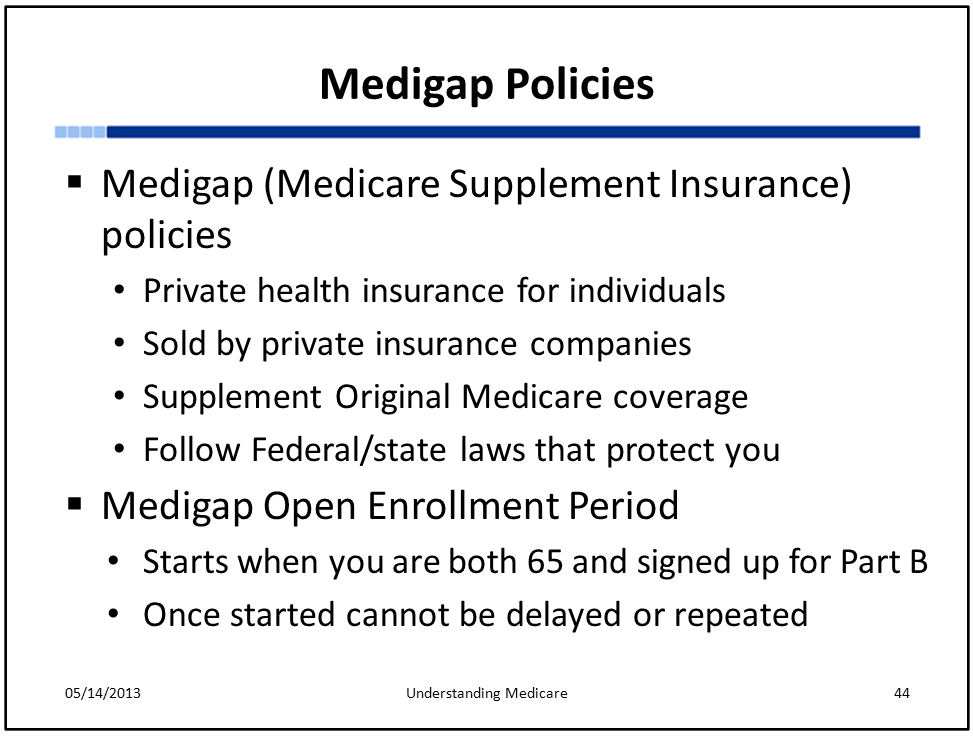
If you get your Medicare Part B–covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, they're supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit 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) policies will not pay for the services you get from the doctor with whom you have a private contract. You can't 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 the doctor.
- Your Medigap policy, if you have one, will not pay anything for the service.
- You'll have to pay whatever this doctor or provider charges you. (The Medicare limiting charge will not apply.)
- Other Medicare plans will not pay for the 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 can't bill Medicare for 2 years for any services provided to anyone with Medicare.



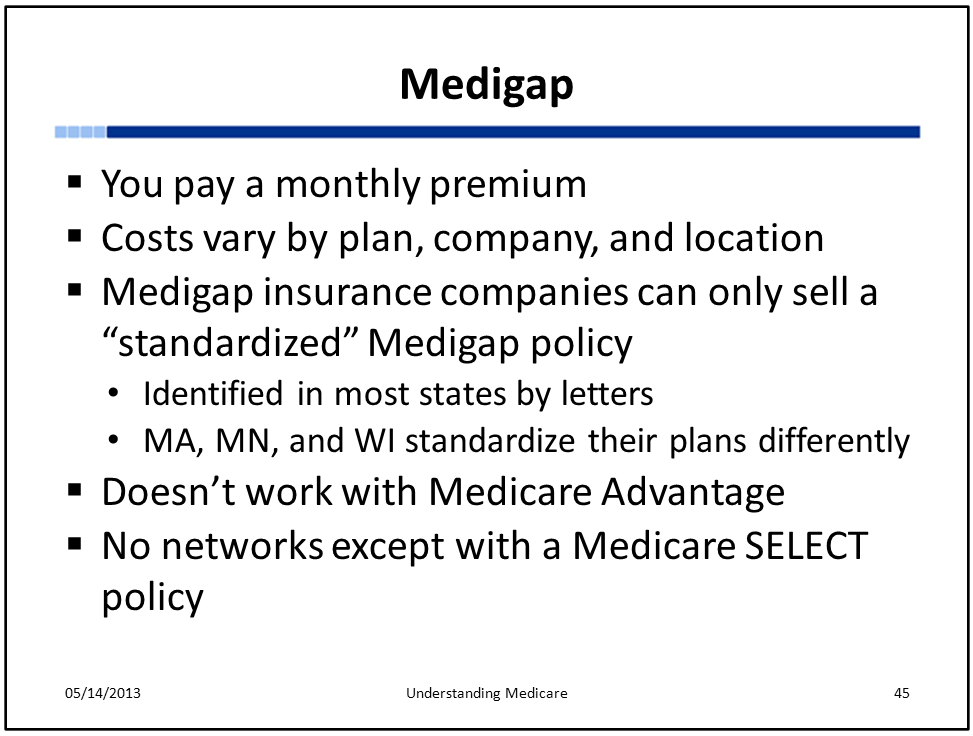
Medigap (Medicare Supplement Insurance) policies

- Are private health insurance that cover only the policy holder, not the spouse;
- Are sold by private insurance companies;
- 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 Medicare 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; and
- Must follow federal and state laws that protect people with Medicare.

Your Medigap Open Enrollment Period starts when you are both 65 and signed up for Part B. Once it has started, it can't be delayed or repeated. During your Medigap Open Enrollment Period, an insurance company can't

- Use medical underwriting;
- Refuse to sell you any Medigap policy it offers;
- Charge you more for a Medigap policy than they charge someone with no health problems; or
- Make you wait for coverage to start (except in certain circumstances).

You can also buy a Medigap policy any time a company will sell you one.



You pay a monthly premium for a Medigap policy to the insurance company that sells it. With a Medigap policy, costs can vary by plan, company, and location.

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. Each company decides which Medigap policies it will sell and the price for each plan, with state review and approval.

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

Medigap policies don't work with Medicare Advantage (MA) plans.

Medigap policies don't have networks, except for Medicare SELECT policies, which require you to use specific hospitals, and in some cases, specific doctors to get full benefits.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Medicare Part B coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%** **
Blood (first 3 pints)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Part A hospice care coinsurance or copayment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Skilled nursing facility care coinsurance			**100%**	**100%**	**100%**	**100%**	50%	75%	**100%**	**100%**
Medicare Part A deductible		**100%**	**100%**	**100%**	**100%**	**100%**	50%	75%	50%	**100%**
Medicare Part B deductible			**100%**		**100%**					
Medicare Part B excess charges					**100%**	**100%**				
Foreign travel emergency (up to plan limits)			**100%**	**100%**	**100%**	**100%**			**100%**	**100%**
							Out-of-pocket limit in 2013			
							$4,800	$2,400		

*Plan F also offers a high-deductible plan in some states.

All Medigap policies cover a basic set of benefits, including

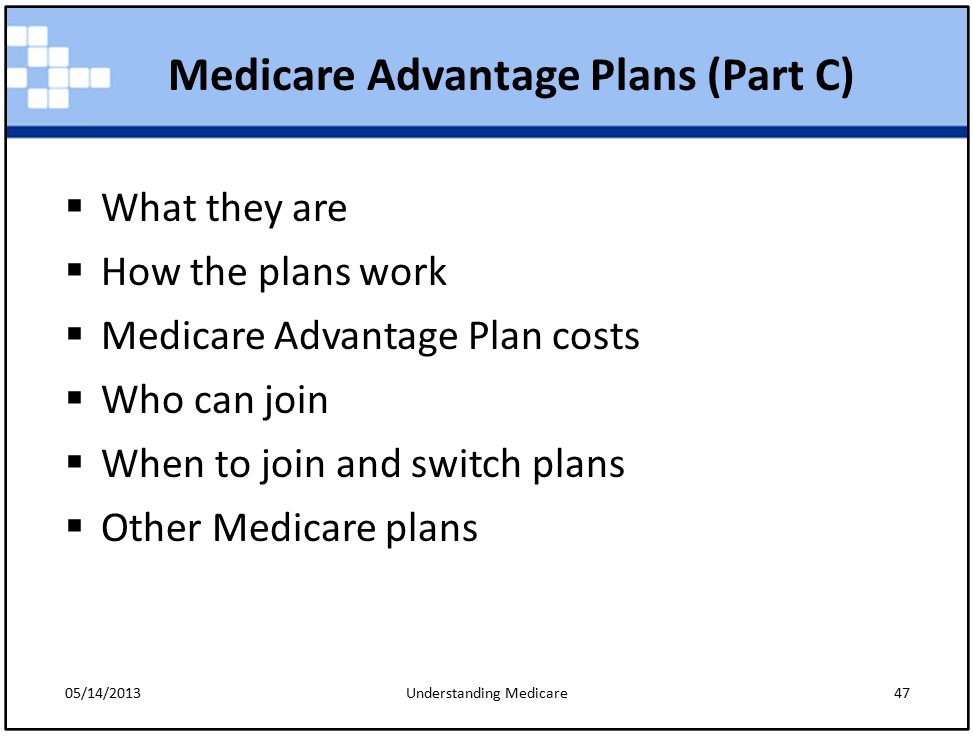
- Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up;
- Medicare Part B coinsurance or copayment;
- Blood (first three pints); and
- Part A Hospice Care coinsurance or copayment.

In addition, each Medigap plan covers different benefits:

- The Skilled Nursing Facility (SNF) care coinsurance is covered by Medigap Plans C, D, F, G, K (at 50 percent), L (at 75 percent), M and N;
- The Medicare Part A deductible is covered by Medigap Plans B, C, D, F, G, K (at 50 percent), L (at 75 percent), M (at 50 percent), and N;
- The Medicare Part B deductible is covered by Medigap Plans C and F;
- The Medicare Part B excess charges are covered by Medigap Plans F and G; and
- Foreign travel emergency costs up to the plan's limits are covered by Medigap Plans C, D, F, G, M, and N.

*Plan F also offers a high-deductible plan in some states.

**Plans K and L have out-of-pocket limits of $4,800 and $2,400, respectively, in 2013.

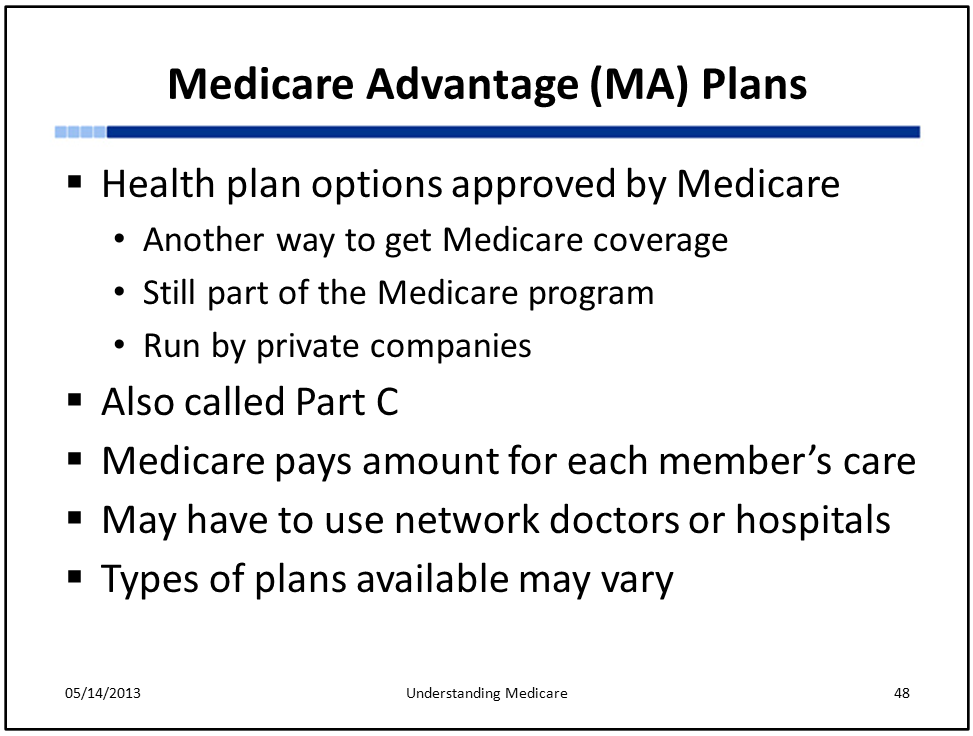


Medicare Advantage (MA) Plans explains the following:

- What they are;
- How the plans work;
- MA plan costs;
- Who can join;
- When to join and switch plans; and
- Other Medicare plans.

Please see Module 11 for more information on MA plans.

NOTE: In this presentation, 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 standalone Medicare Prescription Drug Plans (PDPs).)

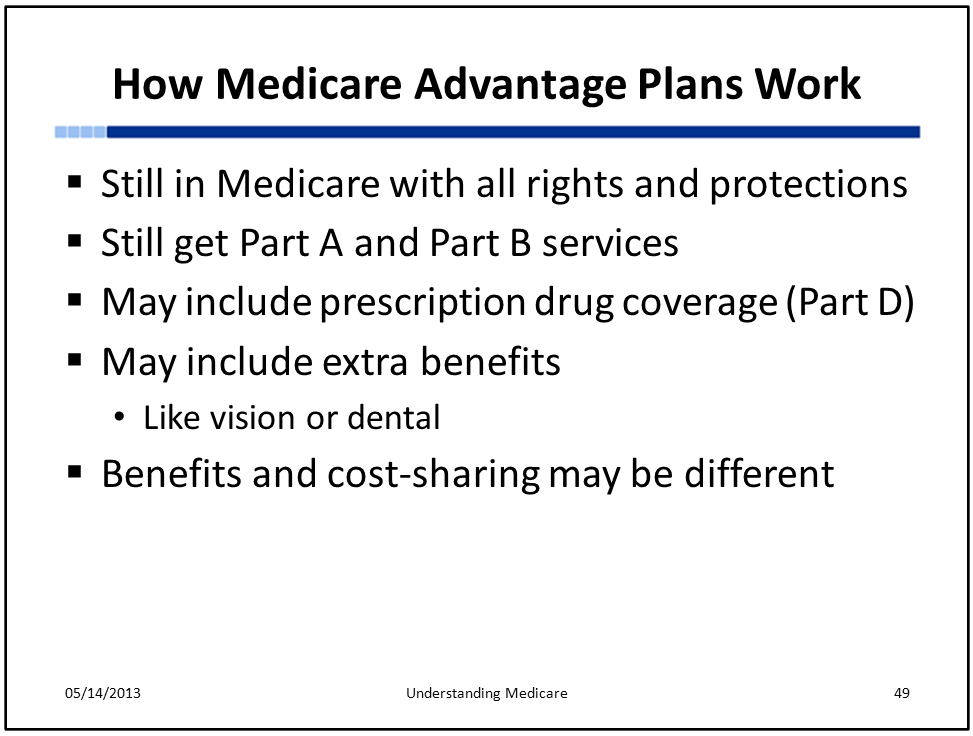


Medicare Advantage (MA) plans are health plan options approved by Medicare and run by private companies. MA is also called Part C.

MA plans are part of the Medicare program; they are just another way to get Medicare coverage.

Medicare pays the plan a certain amount for each member's care.

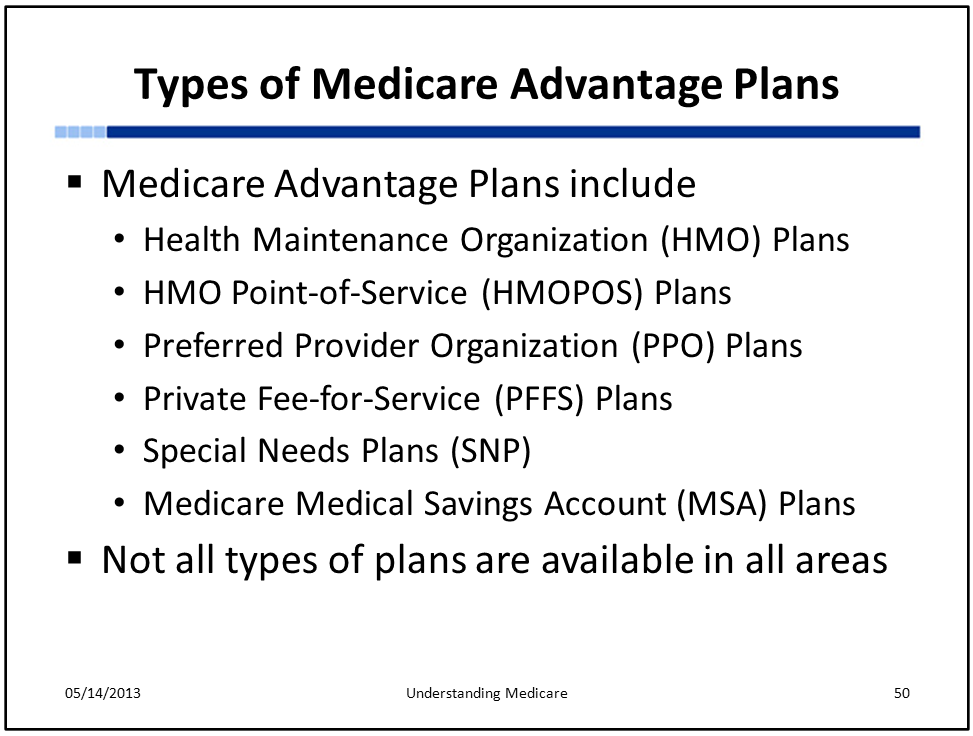
If you join an MA plan, you may have to use a network of doctors and/or hospitals.



If you join a Medicare Advantage (MA) plan, you still have Medicare rights and protections. You still get all your medically necessary Part A and Part B Medicare-covered services.

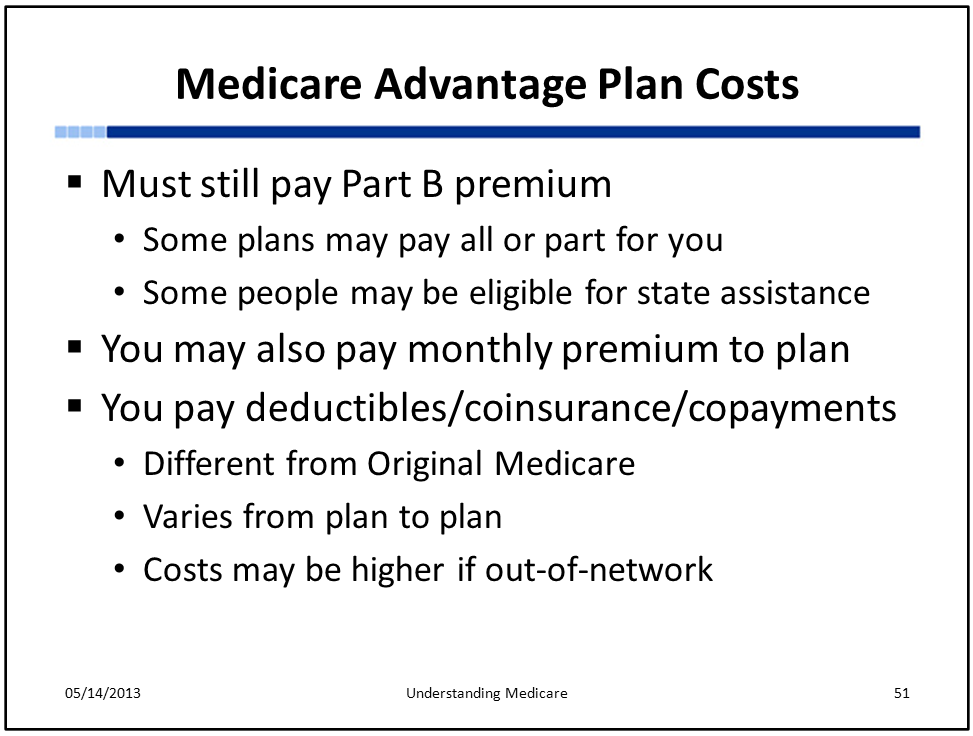
You may get additional benefits offered through the plan, including Medicare prescription drug coverage (Part D). Other extra benefits could include coverage for vision, hearing, or dental care, and/or health and wellness programs.

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



There are six main types of Medicare Advantage (MA) plans. Not all types of plans are available in all areas.

- **Health Maintenance Organization (HMO) plans** — In most HMOs, you can only go to doctors, other health care providers, or hospitals in the plan's network except in an emergency. You may also need to get a referral from your primary care doctor.
- **HMO Point-of-Service (HMOPOS) plans** — These are HMO plans that may allow you to get some services out of network for a higher copayment or coinsurance.
- **Preferred Provider Organization (PPO) plans** — In a PPO, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You usually pay more if you use doctors, hospitals, and providers outside of the network.
- **Private Fee-for-Service (PFFS) plans** — PFFS plans are similar to Original Medicare in that you can generally go to any doctor, other health care provider, or hospital as long as they agree to treat you. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.
- **Special Needs Plans (SNPs)** — SNPs provide focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions.
- **Medical Savings Account (MSA) plans** — This is a plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year.

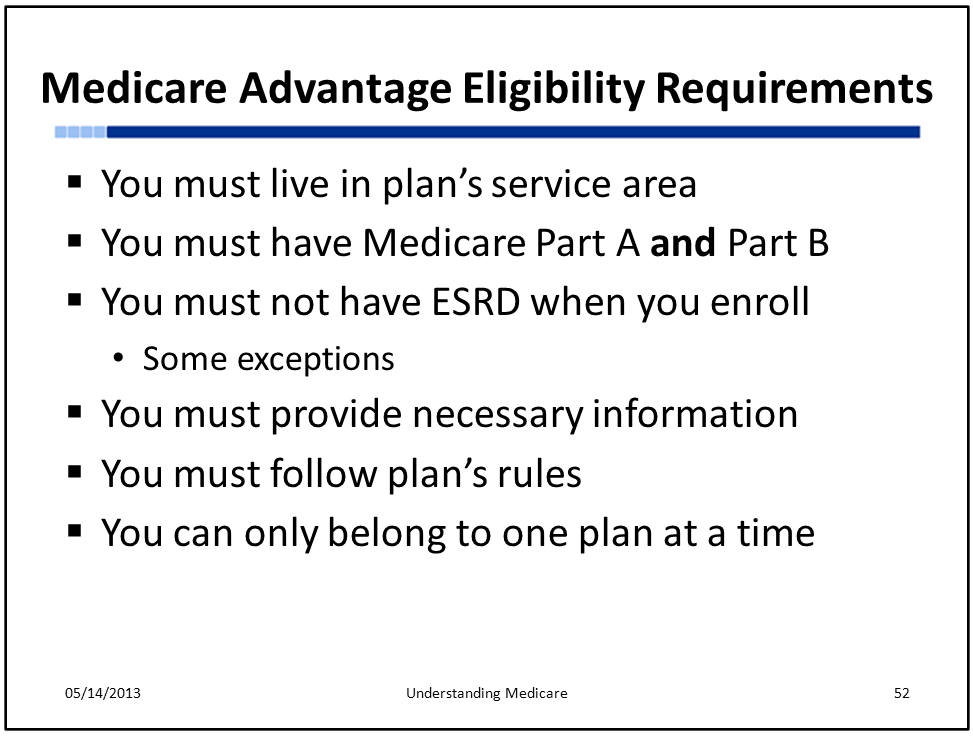


If you join a Medicare Advantage (MA) plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2013 is $104.90 for most people.

- A few plans may pay all or part of the Part B premium for you.
- Some people with limited income and resources may be eligible for state assistance.

When you join an MA plan, there are other costs you may have to pay, including things like

- An additional monthly premium to the plan;
- Deductibles, coinsurance and copayments:
  - May be different from Original Medicare;
  - May vary from plan to plan; and
  - Your costs may be higher if you go out of network.



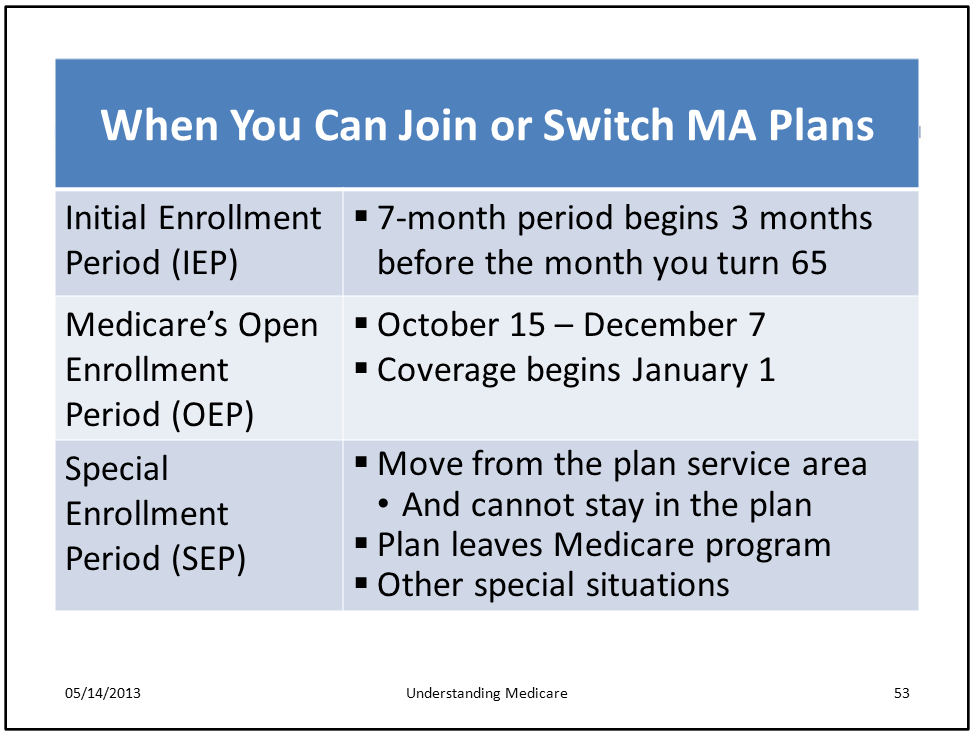
Medicare Advantage (MA) plans are available to most people with Medicare. To be eligible to join an MA plan, you must

- Live in the plan's geographic service area or continuation area;
- Have Medicare Part A and Part B; and
- Not have End-Stage Renal Disease (ESRD) when you enroll. People with ESRD usually can't join an MA 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; and
- Belong to only one plan at a time.

To find out what MA plans are available in your area, visit www.medicare.gov and click on Find Drug and Health Plans to use the Medicare Plan Finder, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

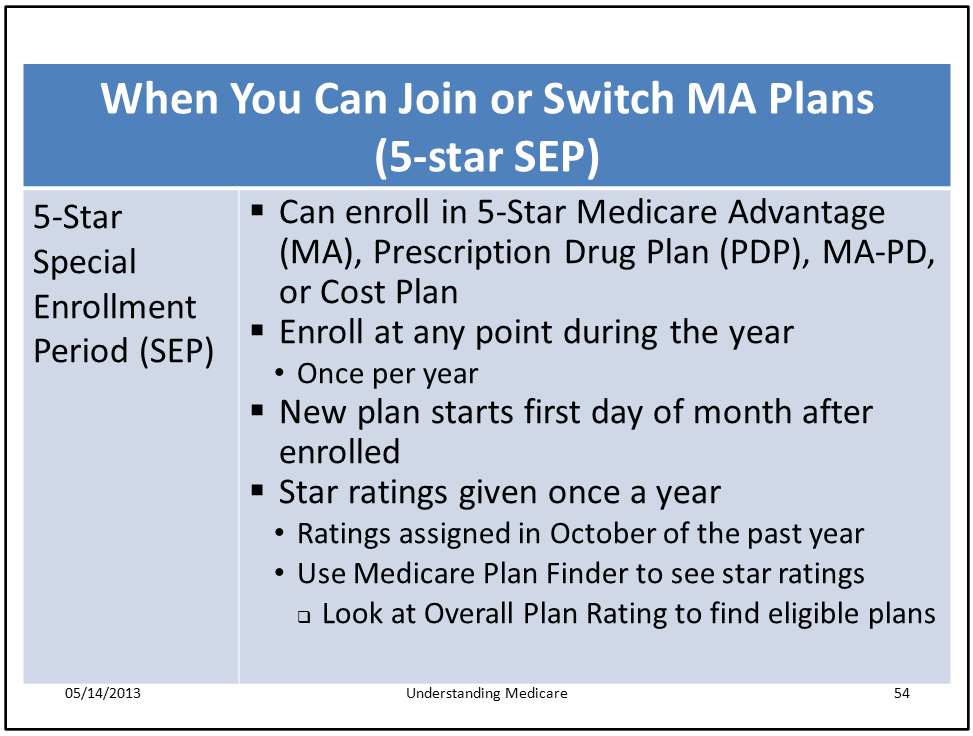


You can join a Medicare Advantage (MA) plan when you first become eligible for Medicare, during your Initial Enrollment Period (IEP), which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B, or during the annual Open Enrollment Period (OEP), and in certain special situations that provide a Special Enrollment Period (SEP). You can only join one MA plan at a time, and enrollment in a plan is generally for a calendar year.

You can switch to another MA plan or to Original Medicare during the annual Open Enrollment Period, which runs from October 15 through December 7 each year.

You can make changes to your MA plan coverage when certain events happen in your life, such as if you move out of your plan's service area or if you lose certain other insurance coverage. These chances to make changes are SEPs. Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year.

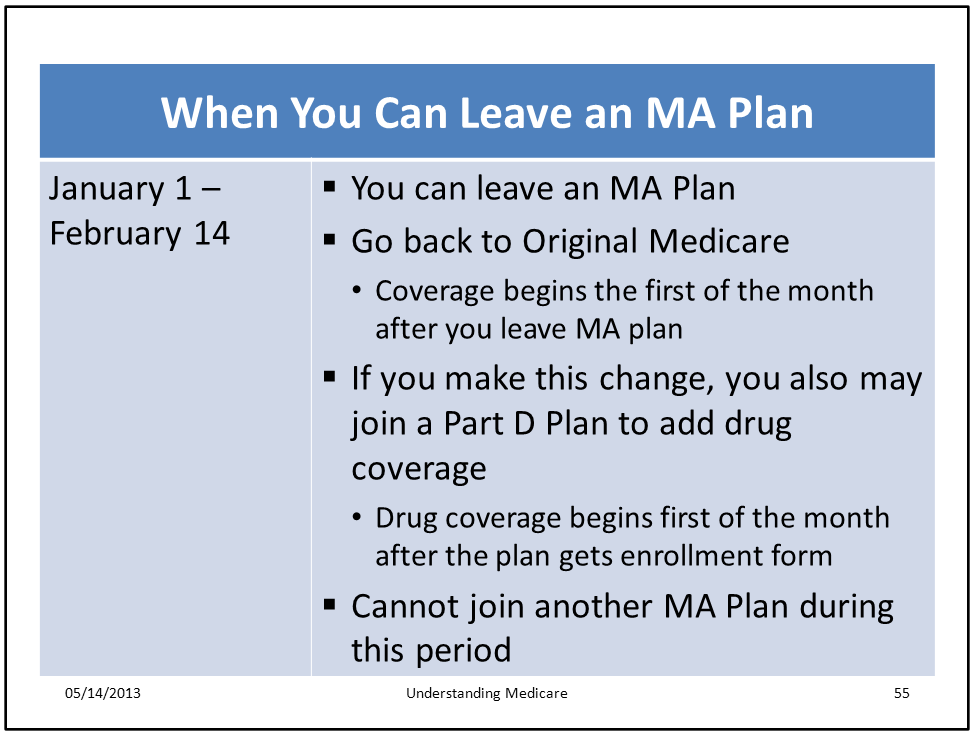
You can only join one MA plan at a time, and enrollment in a plan is generally for a calendar year.



Medicare uses information from member satisfaction surveys, plans, and health care providers to give plans overall star ratings from one to five stars. A 5-star rating is considered excellent. At any time during the year, you can use the 5-Star Special Enrollment Period (SEP) to enroll in any of these types of plans with a 5-star overall rating: Medicare Advantage-only plan, Medicare Advantage plan with prescription drug coverage (MA-PD), Medicare Prescription Drug Plan (PDP), or a Cost Plan, as long as you meet the plan's enrollment requirements (for example, living within the service area). If you're 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 PDPs. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a PDP, if that combination is allowed under CMS rules.

You may use the 5-star SEP to change plans 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 year and you're allowed to make changes only during other appropriate enrollment periods. Your enrollment will start the first day of the month following the month in which the plan receives your enrollment request. Plans are assigned their star rating once per year, in October. The plan won't actually get this rating until the following January 1. To find star rating information, visit the Medicare Plan Finder at www.medicare.gov. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this SEP. The *Medicare & You* handbook doesn't have the full, updated ratings for this SEP.

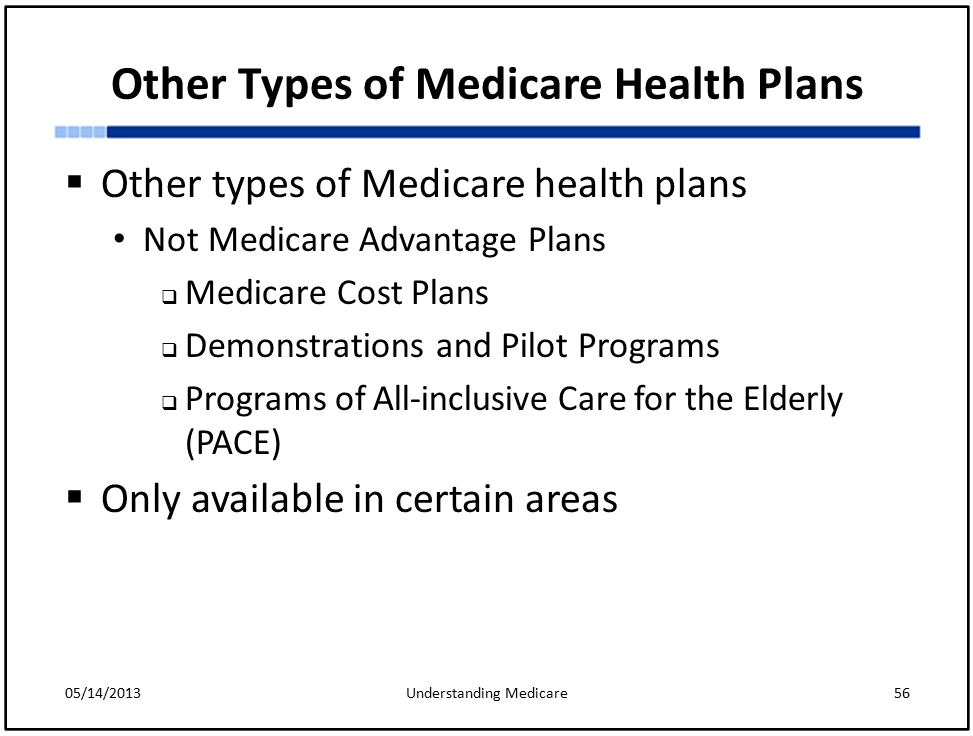
You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that doesn't. You'll have to wait until the next applicable enrollment period to get coverage and may have to pay a penalty.



If you belong to a Medicare Advantage (MA) plan, you can switch to Original Medicare from January 1 through 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.

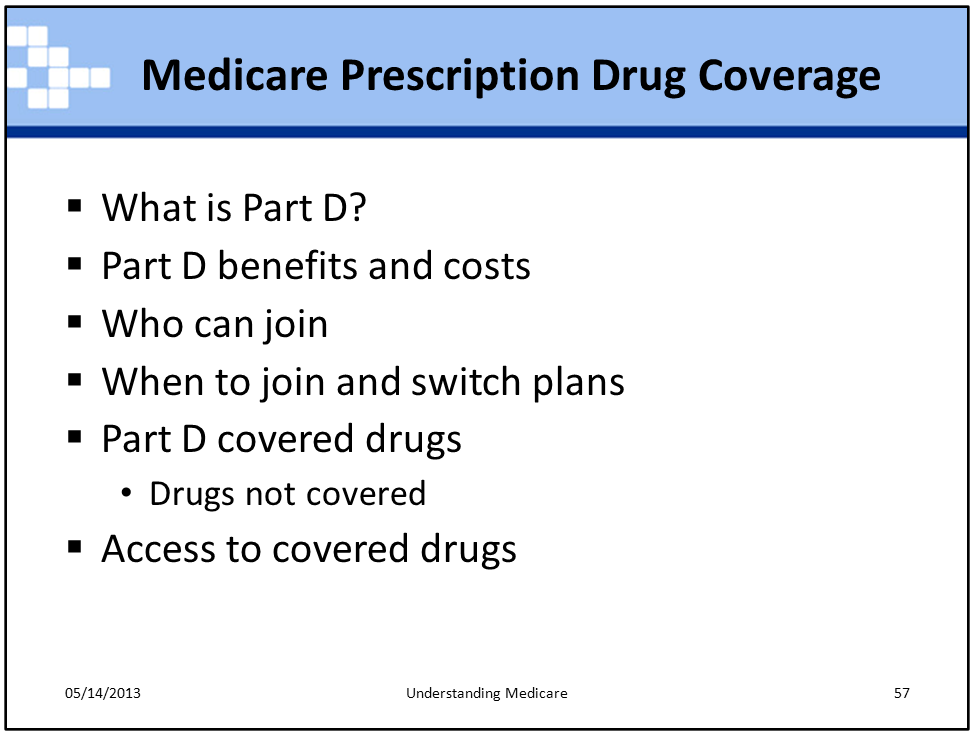
To disenroll from an MA plan and return to Original Medicare during this period, you can make a request directly to the MA plan or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you make this change, you may also join a Medicare Prescription Drug Plan (PDP) to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.



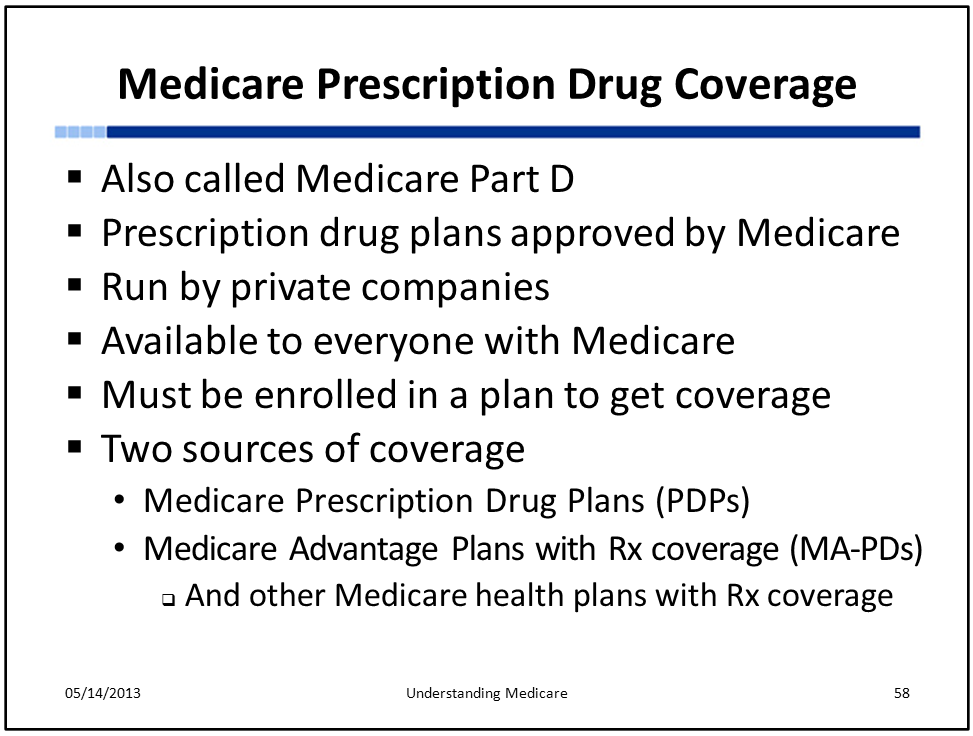
There are three other types of Medicare health plans that are not Medicare Advantage (MA) plans. These plan types are available only in limited areas.

- **Medicare cost plans** — Similar to an 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.



Medicare Prescription Drug Coverage explains the following:

- What Part D is;
- Part D benefits and costs;
- Who can join;
- When to join and switch plans;
- Part D covered drugs; and
  - Drugs not covered
- Access to covered drugs.



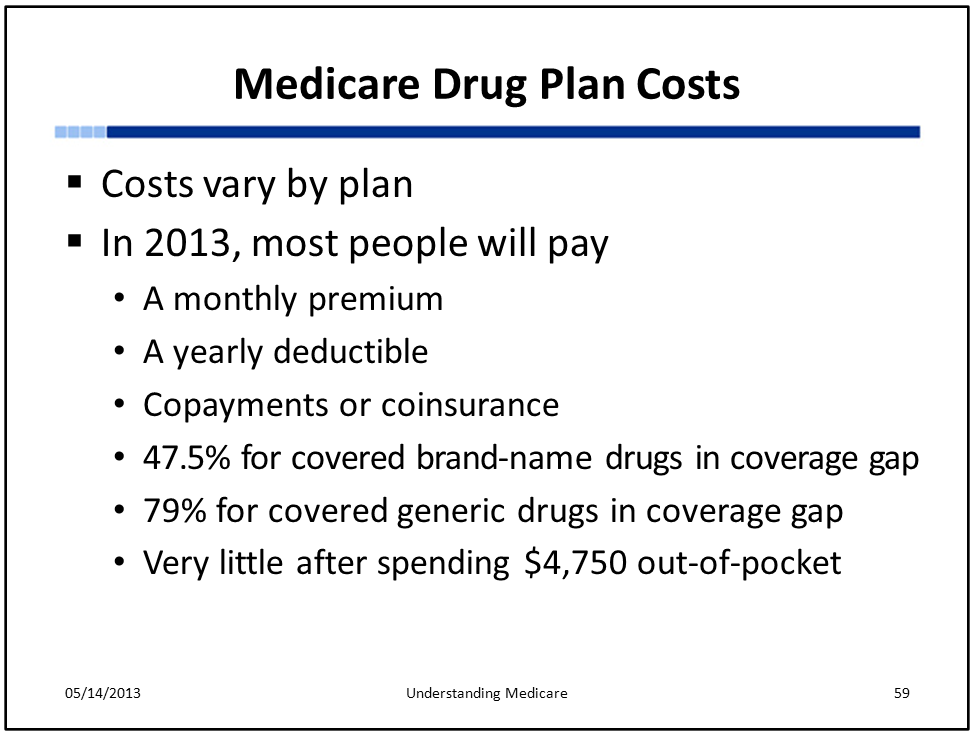
Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for medically necessary brand name and generic prescription drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. All people with Medicare are eligible to enroll in a Medicare Prescription Drug Plan (PDP). You must be enrolled in a plan to get Medicare prescription drug coverage.

You can get Medicare prescription drug coverage in two ways:

1. Medicare PDPs add coverage to Original Medicare and some other types of Medicare plans.
2. Some Medicare Advantage (MA) plans (like an HMO or PPO) and some other Medicare health plans also offer Medicare prescription drug coverage.

The term "Medicare drug plan" is used throughout this presentation to mean both PDPs and MA or other Medicare plans with prescription drug coverage.

NOTE: Some Medigap policies offered prescription drug coverage before January 1, 2006. This is not Medicare prescription drug coverage.



Your costs for prescription drug coverage will depend on the plan you choose and some other factors, such as which drugs you use, which Medicare drug plan you join, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs.

Most people will pay a monthly premium for Medicare prescription drug coverage. You'll also pay a share of your prescription costs, including a deductible, copayments, and/or coinsurance.

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs. You enter the coverage gap after you and your drug plan have spent a certain amount for covered drugs. In 2013, once you enter the coverage gap, you pay 47.5 percent of the plan's cost for covered brand-name drugs and 79 percent of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Not everyone will enter the coverage gap (see page 60).

With every plan, once you've paid $4,750 out of pocket for drug costs in 2013 (including payments from other sources, such as the discount paid for by the drug company in the coverage gap) you leave the coverage gap and pay 5 percent (or a small copayment) for each drug for the rest of the year.

NOTE: See Appendix A for the 2013 standard Medicare Part D cost and benefit structure.

Standard Structure in 2013

Example: Ms. Smith joins the ABC Prescription Drug Plan. Her coverage begins on January 1, 2013. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium – Ms. Smith pays a monthly premium throughout the year.			
1. Yearly deductible →	**2. Copayment or coinsurance (what you pay at the pharmacy)** →	**3. Coverage gap** →	**4. Catastrophic coverage**
Ms. Smith pays the first $325 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their **combined** amount (plus the deductible) reaches $2,970.	Once Ms. Smith and her plan have spent $2,970 for covered drugs, she's in the coverage gap. In 2013, she pays 47.5% of the plan's cost for her covered brand-name prescription drugs and 79% of the plan's cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,750 out-of-pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.

Very few Medicare drug plans follow the standard structure design. Your costs will vary.

Monthly premium – Most drug plans charge a monthly fee that differs from plan to plan. You pay this in addition to the Part B premium (if you have Part B). If you belong to a Medicare Advantage (MA) plan (like an HMO or PPO) that includes drug coverage, the monthly plan premium may include an amount for prescription drug coverage.

Yearly deductible (you pay up to $325 in 2013) — This is the amount you pay each year for your prescriptions before your plan begins to pay. No Medicare drug plan may have a deductible more than $325 in 2013. Some drug plans don't have a deductible.

Copayments or coinsurance (you pay approximately 25 percent) — These are the amounts you pay for your covered prescriptions after you pay the deductible (if the plan has one). You pay your share and the drug plan pays its share for covered drugs.

Coverage gap — The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs ($2,970 in 2013). In 2013, once you enter the coverage gap, you pay 47.5 percent of the plan's cost for covered brand-name drugs and 79 percent of the plan's cost for covered generic drugs until you reach the end of the coverage gap. Certain costs count toward you getting out of the gap, including your yearly deductible, coinsurance, and copayments, the discount you get on covered brand-name drugs in the gap, and what you pay in the gap. However, the drug plan premium, what you pay for drugs that aren't covered, and the discount for covered generic drugs in the coverage gap don't count toward getting you out of the coverage gap.

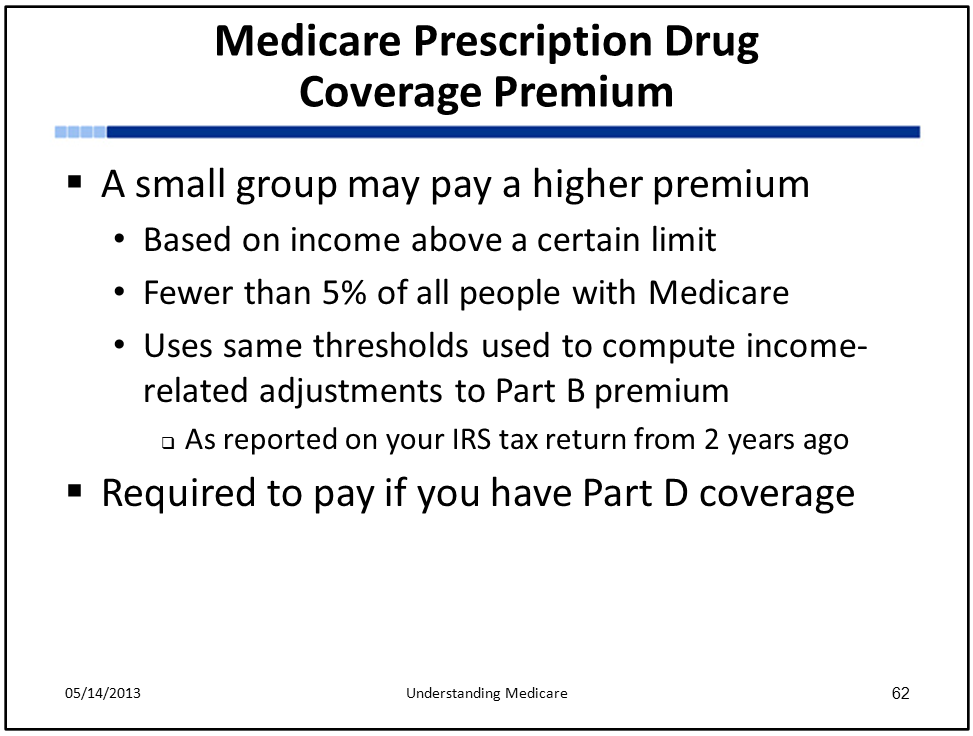
Catastrophic coverage (you pay 5 percent) — Once you reach your plan's out-of-pocket limit, you leave the coverage gap, and automatically get catastrophic coverage, where you only pay a small coinsurance or copayment for covered drugs for the rest of the year.

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
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%

Your discount on drugs will increase each year when you're in the coverage gap until 2020, when you'll pay approximately 25 percent for both covered generic and brand-name drugs when in the gap.

NOTE: In 2013, you pay 47.5 percent of dispensing and vaccine administration fees for brand-name drugs in the coverage gap (unless you get Extra Help). Medicare drug plans pay for the remaining 52.5 percent of these fees. Medicare drug plans will pay an increasing amount of these fees until 2020. In 2013, you also pay 79 percent of the ingredient cost, sales tax, and dispensing and vaccine administration fees for generic drugs in the coverage gap.



A small group—less than 5 percent of all people with Medicare—may pay a higher monthly premium for Medicare Prescription Drug Coverage based on their income. If your income is above a certain limit, you'll 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 figure out 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 adjustment amount (IRMAA).

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

If you don't pay your entire Part D premium (including the extra amount), you may be disenrolled from your Medicare drug plan. You must pay both the extra amount and your plan's premium each month to keep Medicare prescription drug 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: SSA, SSA Publication No. 05-10536, March 2012.

Part D Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2011 was		In 2013 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 + $48.30*
Above $214,000	Above $428,000	YPP + $66.60*
*per month		

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You pay only your plan premium if your yearly income in 2011 was $85,000 or less for an individual or $170,000 or less for a couple.

If you reported a modified adjusted gross income of more than $85,000 (individuals and married individuals filing separately) or $170,000 (married individuals filing jointly) on your IRS tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount (IRMAA). You pay this extra amount in addition to your monthly Medicare drug plan premium.

Below are the 2013 Part D premiums based on the modified adjusted gross income for an individual. The income ranges for joint returns are double that of individual returns.

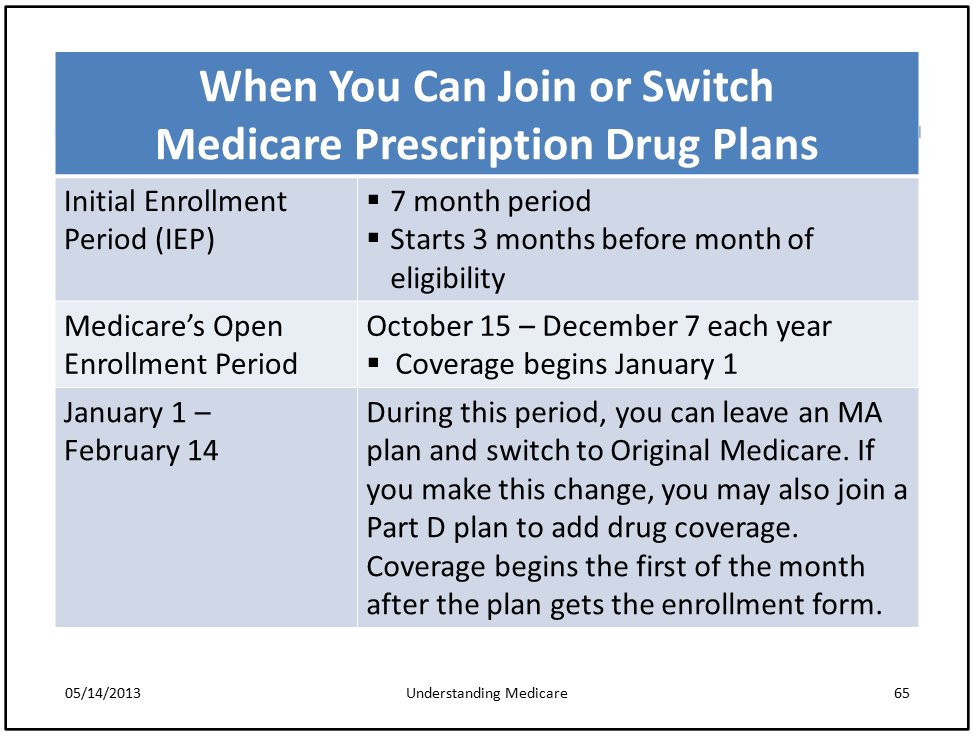
- $85,000 or less, the Part D premium is your plan premium (YPP);
- $85,000.01 - $107,000, the Part D premium is YPP + $11.60 per month;
- $107,000.01 - $160,000, the Part D premium is YPP + $29.90 per month;
- $160,000.01 - $214,000 the Part D premium is YPP + $48.30 per month; and
- Above $214,000, the Part D premium is YPP + $66.60 per month.

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

To join a Medicare Prescription Drug Plan (PDP), you must have Medicare Part A and/or Part B. To join a Medicare Advantage (MA) plan with prescription drug coverage, you must have both Medicare Part A and Part B. To join a Medicare Cost Plan with prescription drug coverage, you must have Medicare Part A and Part B, or have Medicare Part B only.

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 United States and its territories, or if you're incarcerated, you're not eligible to enroll in a plan and, therefore, can't get coverage.

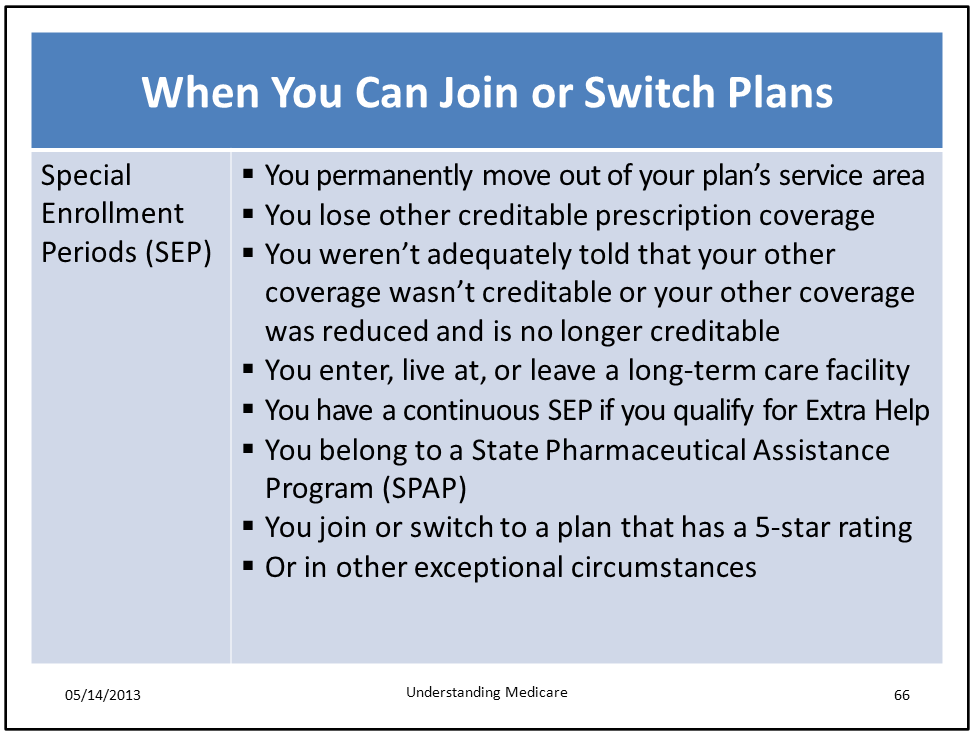
Medicare drug coverage isn't automatic. Most people must enroll in a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, most must take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare drug plan unless you decline coverage or join a plan yourself. 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, during your Initial Enrollment Period (IEP), which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B.

Between October 15 and December 7, anyone can join, switch, or drop a Medicare drug plan. The change will take effect on January 1 as long as the plan gets your request by December 7.

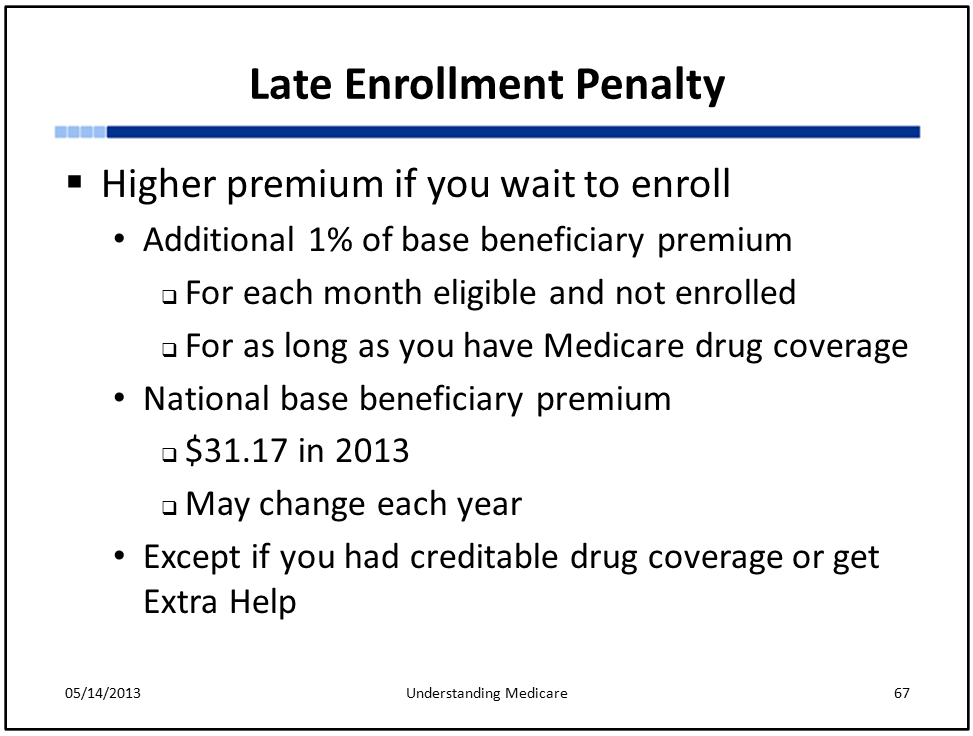
If you belong to a Medicare Advantage (MA) plan, you can switch back to Original Medicare from January 1 through February 14 each year. If you go back to Original Medicare during this time, coverage under Original Medicare will take effect on the first day of the month following the date on which the election or change was made. To disenroll from an MA plan and return to Original Medicare during this period, you must make a request directly to the MA organization, call 1-800-MEDICARE, or enroll in a standalone Prescription Drug Plan (PDP). If you make this change, you may also join a Medicare PDP to add drug coverage.



You can make changes to your Medicare prescription drug coverage when certain events happen in your life, such as if you move out of your plan's service area or if you lose other insurance coverage. These chances to make changes are called Special Enrollment Period (SEPs). Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year. The SEPs listed below are examples. The list doesn't include every situation.

- If you permanently move out of your plan's service area.
- If you lose your other creditable prescription drug coverage.
- If you weren't adequately informed that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable.
- When you enter, live at, 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 plan at any time.
- You belong to a State Pharmaceutical Assistance Program.
- You join or switch to a plan that has a 5-star rating.
- Or in other exceptional circumstances, such as if you no longer qualify for Extra Help.

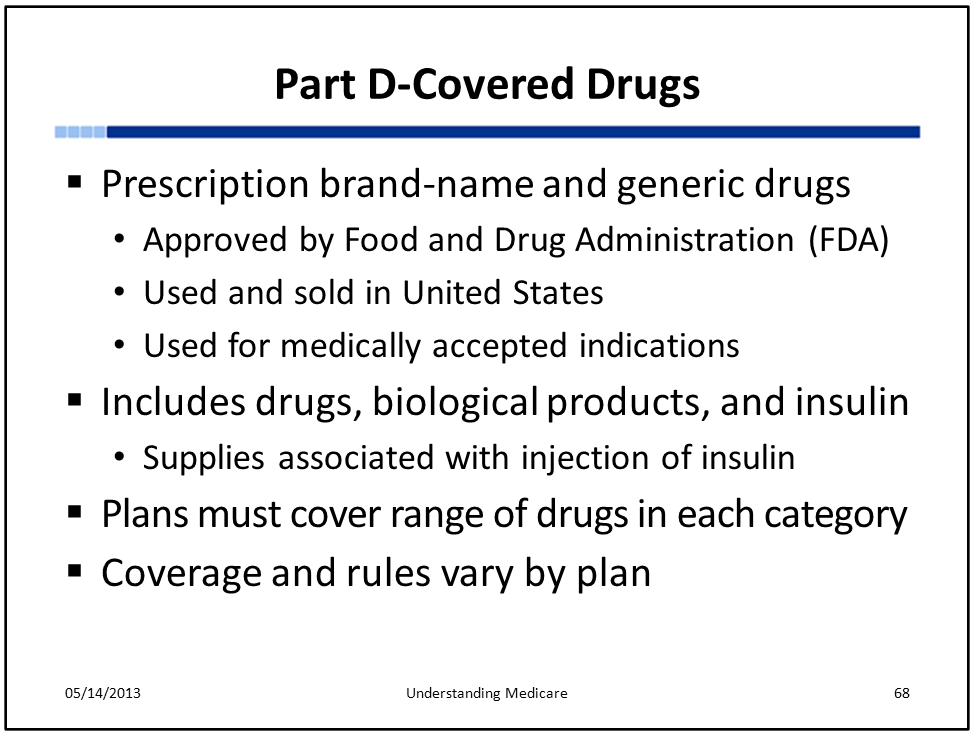
You may be eligible for a Medicare Part B SEP if you are over age 65 and you (or your spouse) are still working and have health insurance through active employment. It's important to remember that the SEPs for Part B and Part D have different time frames for when you need to sign up for coverage. Your Part B SEP lasts for 8 months and begins the month after your employment ends. However, your Part D SEP lasts for only 2 full months after the month your employer coverage ends.



If you choose not to join a Part D plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you enroll later. The penalty is calculated by multiplying the 1 percent penalty rate by the national base beneficiary premium ($31.17 in 2013), by the number of full months you were eligible to join a Medicare drug plan but didn't and went without other creditable prescription drug coverage. The penalty calculation isn't based on the premium of your plan. The final amount is rounded to the nearest $.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

If you have creditable coverage when you first become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won't have to pay a higher premium if you get Extra Help paying for your prescription drugs (see Lesson 4). If you don't agree with your late enrollment penalty, you may ask Medicare for a review or reconsideration by filling out a reconsideration request form (that your plan will send you), and you'll have the chance to give proof that supports your case.

Example: Mrs. Jones didn't join a Medicare Prescription Drug Plan when she was first eligible: June 15, 2009. She joined a Medicare drug plan between October 15 and December 7, 2011, for an effective date of January 1, 2012. Since Mrs. Jones didn't join when she was first eligible and went without other creditable prescription drug coverage for 30 months (July 2009 through December 2011), she'll be charged a monthly penalty of $9.40 in 2013 ($31.17 national base beneficiary premium x .01 penalty rate x 30 months = $9.35, rounded to nearest $.10 = $9.40). She pays this penalty each month in addition to her plan's monthly premium.



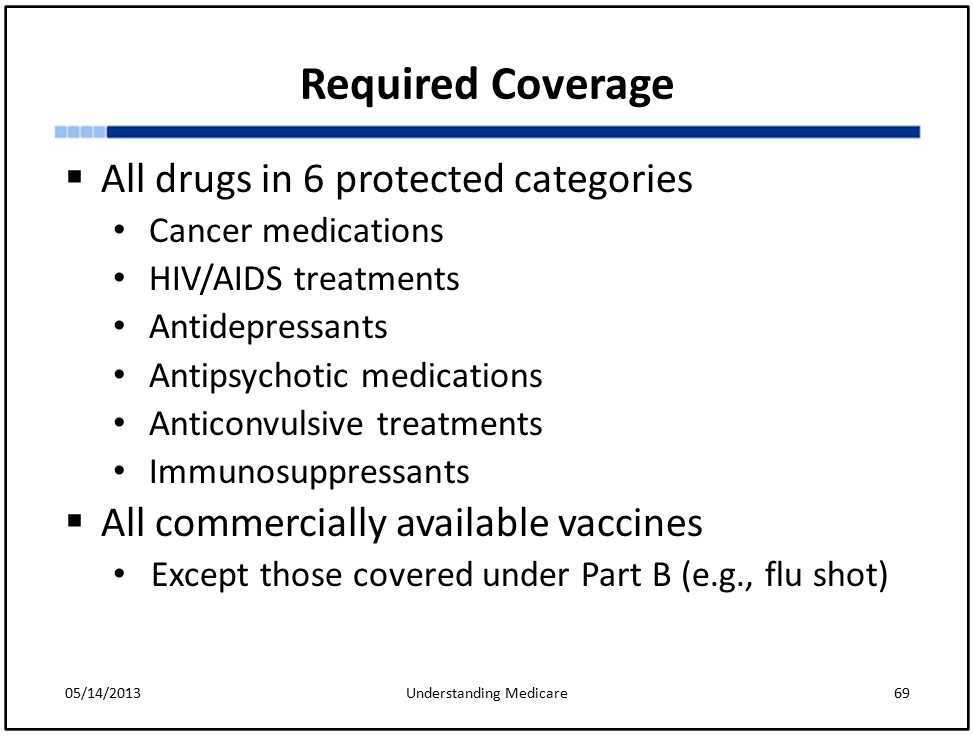
Medicare drug plans cover generic and brand-name drugs. To be covered by Medicare, a drug must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication.

Medicare covers prescription drugs, insulin, and biological products (e.g., antibodies, proteins, cells, etc.). Medicare also covers medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists for each plan must include a range of drugs in the most commonly prescribed categories. All Medicare drug plans generally must cover at least two drugs per drug category, but the plans may choose which specific drugs they cover. Coverage and rules vary by plan, which can affect what you pay.

A plan's prescription drug list may 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 may ask for an exception.

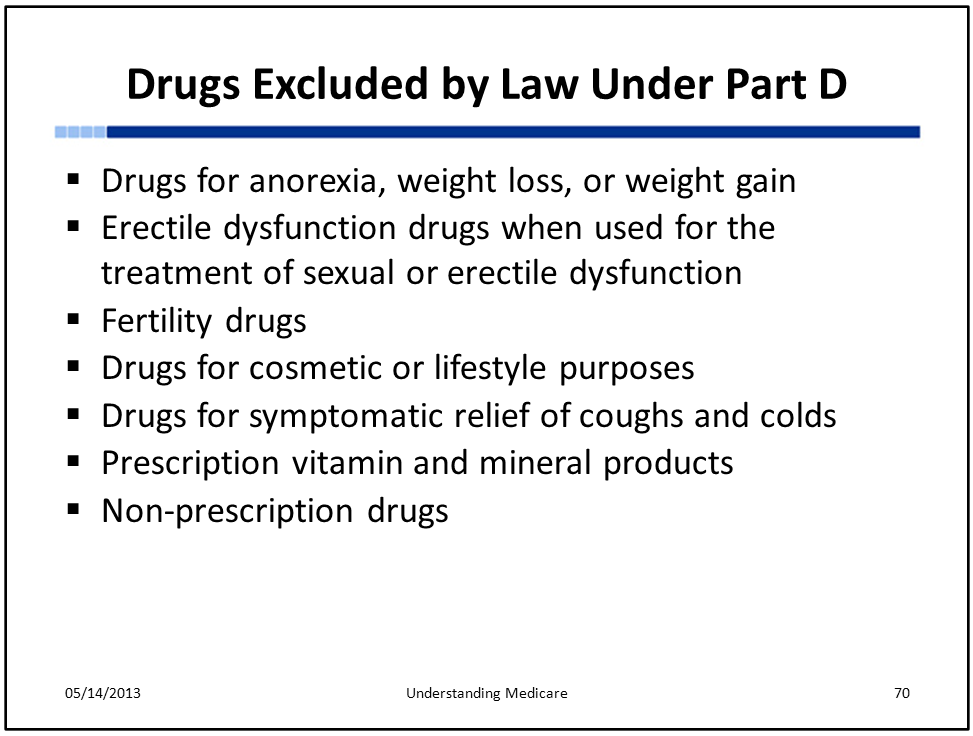
NOTE: There are older drugs that never went through FDA approval processes. As plans review their formularies and find these drugs, they are removed from the formulary.



Medicare drug plans must cover all drugs in six categories to treat certain conditions:

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

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine (but not vaccines covered under Part B, such as the flu and pneumococcal pneumonia shots). You or your provider can contact your Medicare drug plan for more information about vaccine coverage.

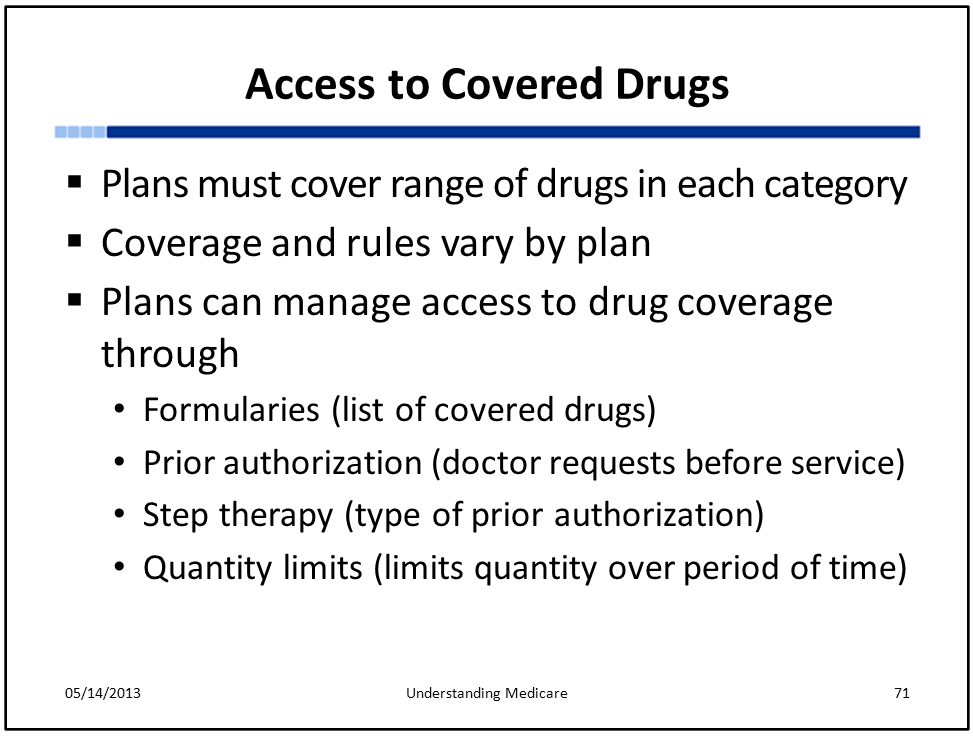


By law, Medicare doesn't cover the following drugs:

- Drugs for anorexia, weight loss, or weight gain.
- Erectile dysfunction drugs when used to treat sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which use the FDA approved the drugs. For example, a Medicare drug plan may cover an erectile dysfunction drug when used to treat an enlarged prostate (also known as benign prostatic hyperplasia, or BPH).
- 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.

NOTE: Barbiturates and benzodiazepines were previously excluded from coverage under Medicare Part D. As of January 1, 2013, Part D covers barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines.



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 the following:

- Formularies (list of covered drugs). To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.
- Prior authorization. Before the plan will cover a particular drug, your doctor or other prescriber must first show you have a medically necessary need for that particular drug.
- Step therapy (type of prior authorization). You must first try a less expensive drug on the plan's formulary that has been proven effective for most people with your condition before you can move up a step to a more expensive drug. For instance, you may be required to first to try a generic drug (if available) before you can get a similar, more expensive brand-name drug covered.
- Quantity limits. For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time.

Check Your Knowledge
Lesson 2 – Program Basics

Answer the following questions:

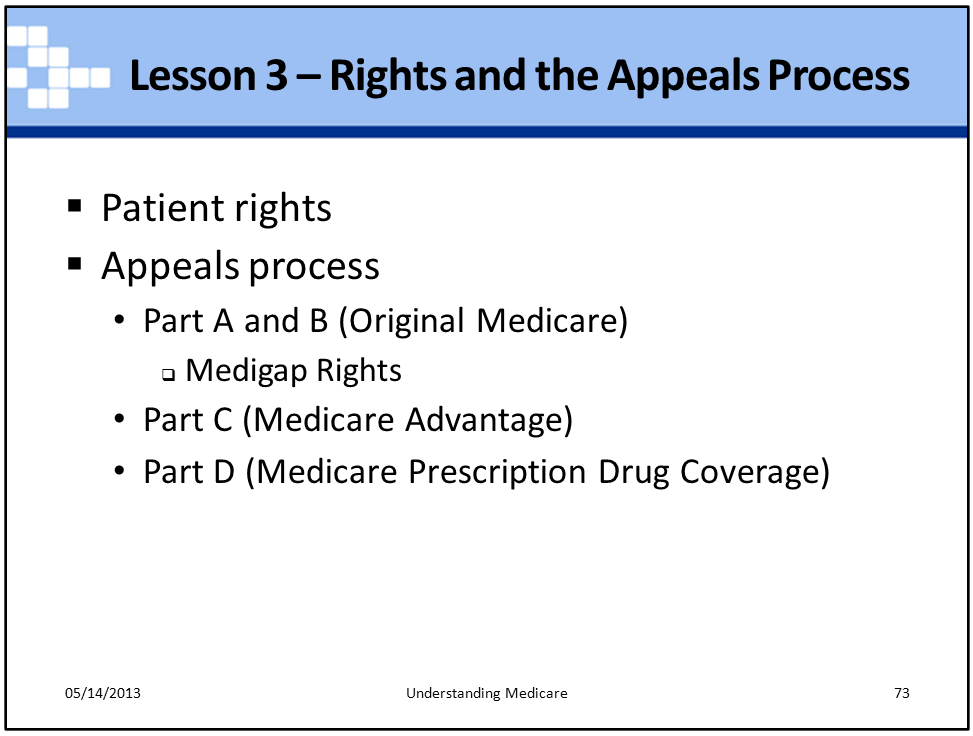
1. Providers and suppliers that don't accept assignment may charge up to

   a. 10 percent more
   b. 20 percent more
   c. 15 percent more
   d. An unlimited amount more

2. True or False: Everyone with a Part D plan pays the same premium.

   a. True
   b. False

Refer to page 100 to check your answers.



Lesson 3, *Rights and the Appeals Process*, provides an overview of your Medicare rights and the process for appealing certain decisions.

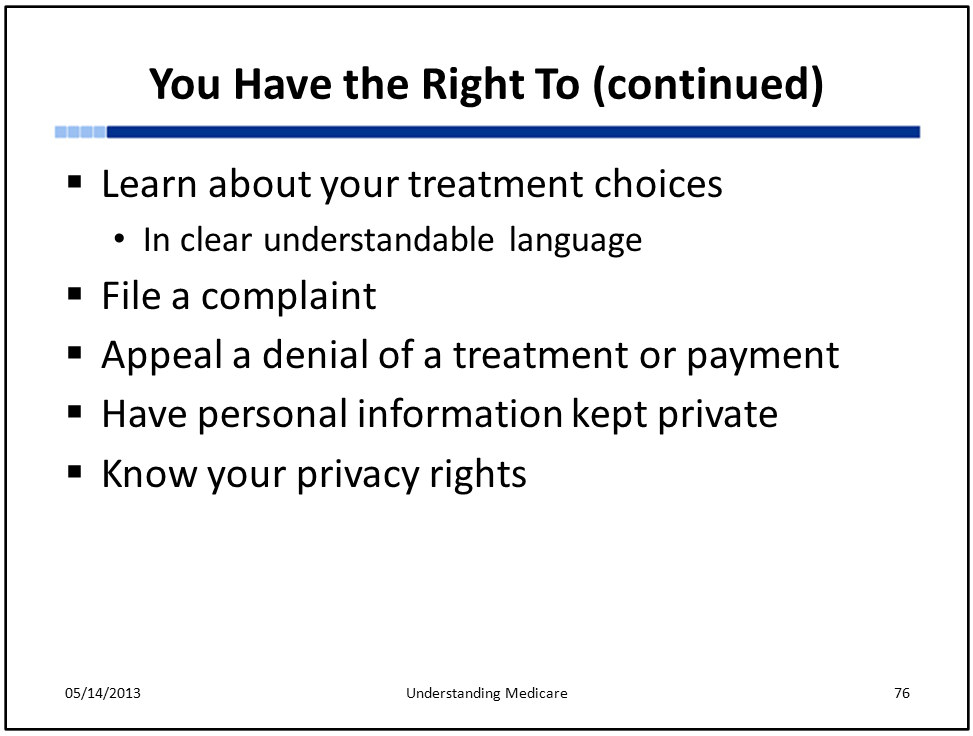
- Patient rights
- Appeals process
  - Part A and B (Original Medicare)
    - Medigap rights
  - Part C (Medicare Advantage)
  - Part D (Medicare Prescription Drug Coverage)

You have certain guaranteed rights under the Medicare program in Original Medicare, Medicare Advantage (MA) plans and other health plans, and Medicare Prescription Drug Plans (PDPs).

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;
- Get urgently needed care; and
  - 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 answers to your Medicare questions.
  - You can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - You can also contact your State Health Insurance Assistance Program (SHIP). Contact numbers can be found via www.medicare.gov and on the back of your *Medicare & You* handbook, CMS Product No. 10050.



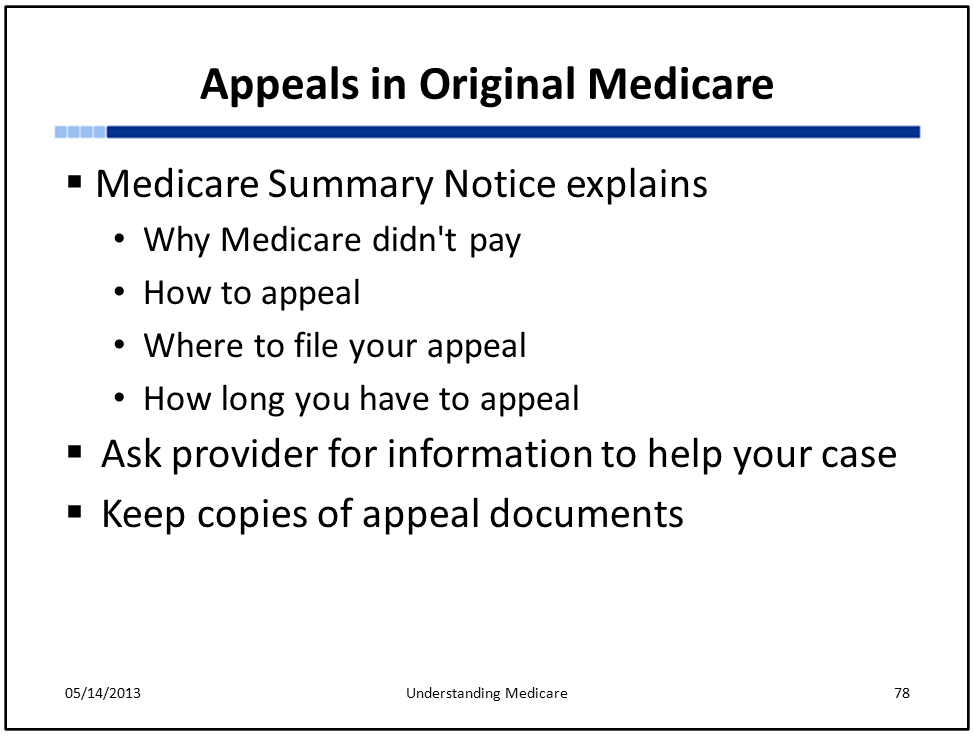
You also have the right to

- 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; and
- Know your privacy rights.

You have the right to file a complaint about concerns or problems you may have had in getting health care services 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 (for example, if you think 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).

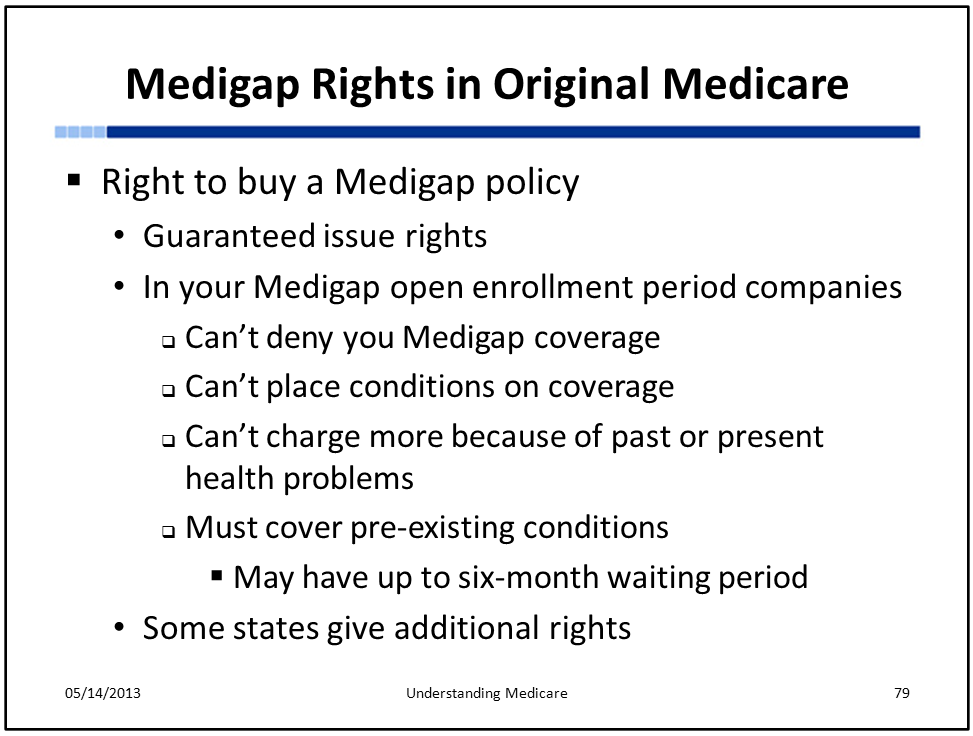
For more information about filing an appeal or complaint, call your plan, your (State Health Insurance Assistance Program) SHIP, or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



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've 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 tell you why Medicare didn't pay your bill and how you can appeal. It'll tell you where to file the appeal and the time limit for filing your appeal.

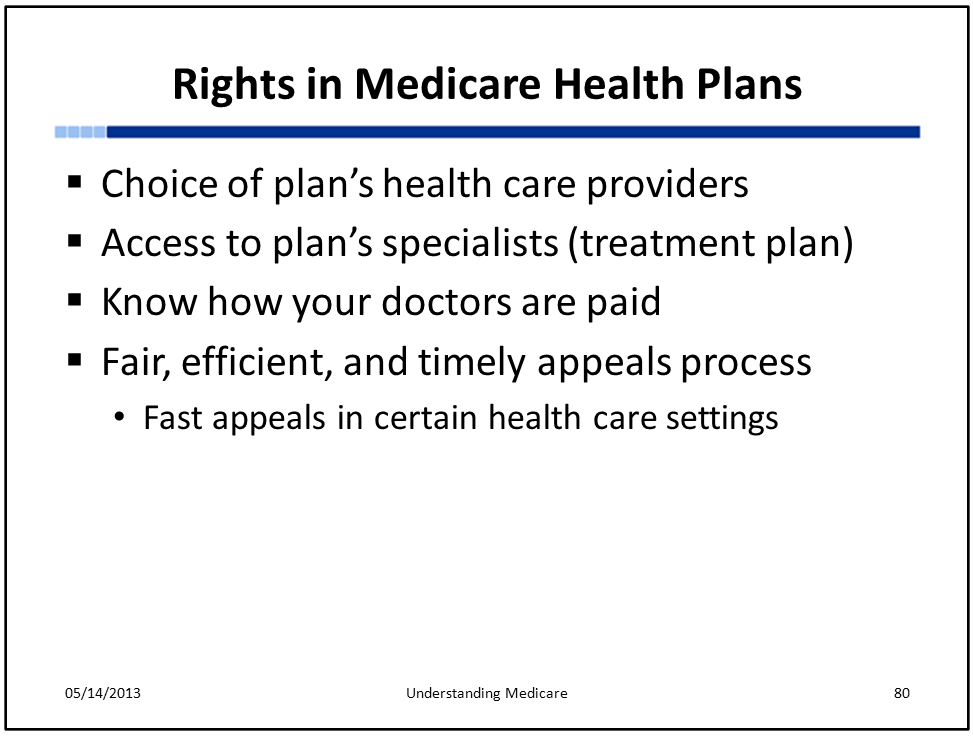
You should keep a copy of everything you send to Medicare as part of your appeal.



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

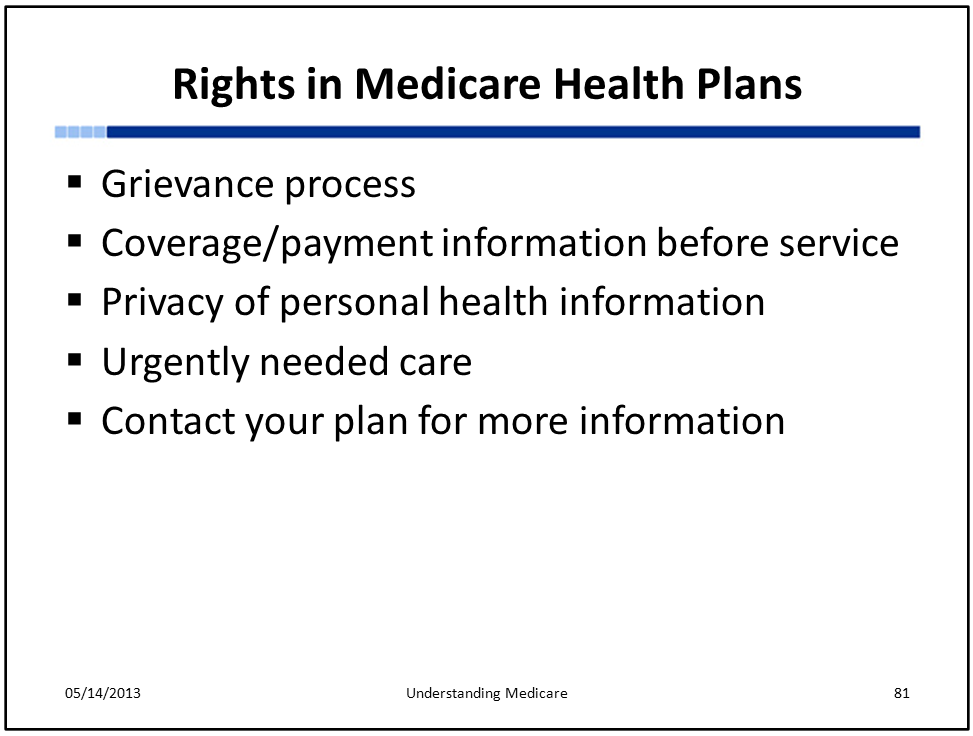
- To buy a Medigap (Medicare Supplemental Insurance) policy.
  - In some situations, you have the right to buy a Medigap policy. When you have guaranteed issue rights, the Medigap plan:
    - Can't deny you Medigap coverage or place conditions on your policy;
    - Must cover you for pre-existing conditions; and
    - Can't charge you more for a policy because of past or present health problems.
  - You have the right to buy a Medigap policy during your Medigap open enrollment period (6-month period that starts when you 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 up to 6 months for coverage of a preexisting condition.
  - Some states offer additional rights to purchase Medigap policies.

NOTE: Module 3, *Medigap (Medicare Supplement Insurance) Policies*, 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

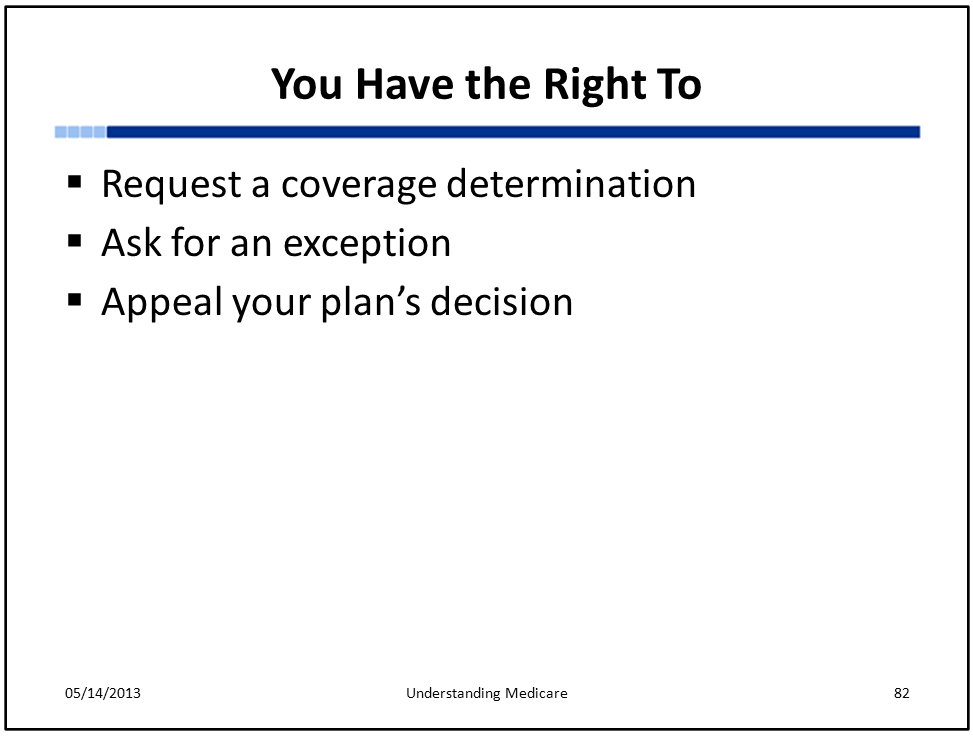
- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have 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 (for example, 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 what will be covered, or to get information about your coverage rules.
- 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 isn't a serious threat to your health. If you're in a Medicare health plan, health care providers in the plan's network generally provide care if you're in the plan's service area. If you're out of your plan's service area for a short time (less than 6 months) and can't wait until you return home, the health plan must pay for urgently needed care.

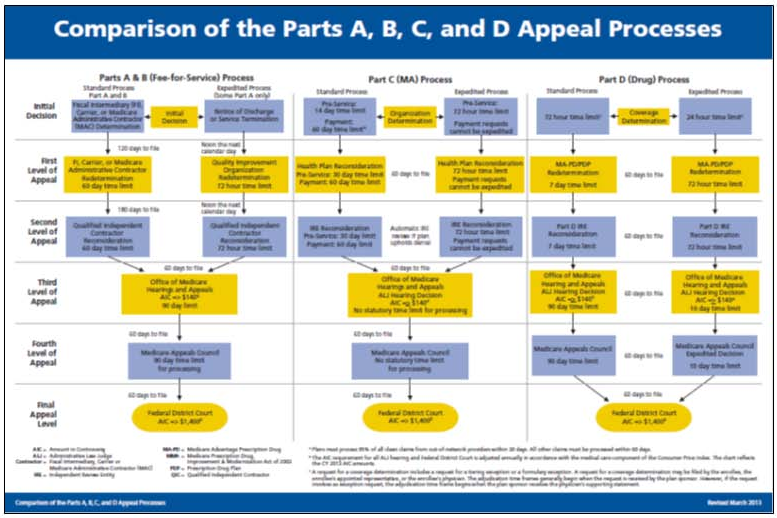
For more information about your rights and protections, read your plan's membership materials or call your plan.



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

- **Right to request a coverage determination** — A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered, whether you have met all the requirements for getting a requested drug, and how much you must pay for a drug. You or your prescriber must contact your plan to ask for a coverage determination.
- **Right to ask for an exception** — An exception is a type of coverage determination. There are two types of exceptions: tier exceptions (such as getting a Tier 3 drug at the Tier 2 cost) and formulary exceptions (either coverage for a drug not on the plan's formulary, or relaxed access requirements). If you want to make an exception request, you'll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception. The prescriber may give the statement verbally or in writing.
- **Right to appeal your plan's decision** — If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully, and call your plan if you have questions.

Parts A, B, C, and D Appeal Processes



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

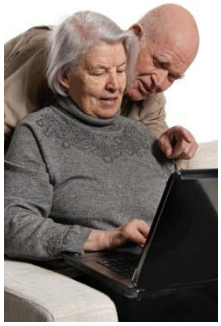
For more information about appeals, go to www.medicare.gov and view the publication *Your Medicare Rights and Protections*, CMS Product No. 10112.

Please see Module 2 for more information about Medicare rights and appeals.

NOTE: A larger copy of this chart is provided in the corresponding workbook. See Appendix B.

Check Your Knowledge
Lesson 3 – Rights and the Appeals Process

Answer the following questions:



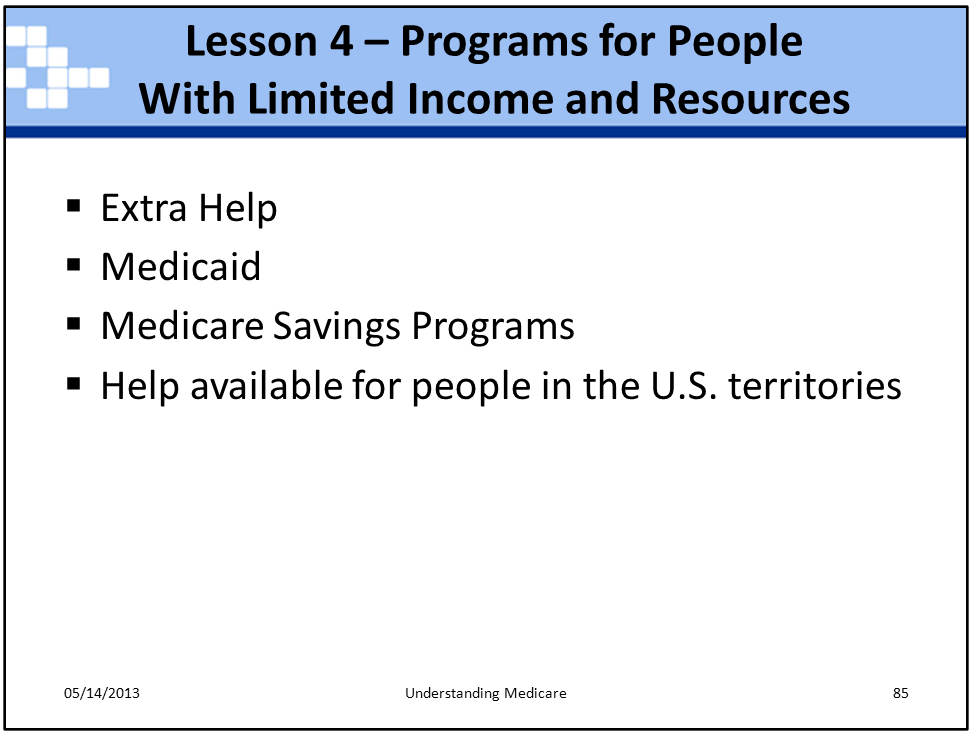
1. You have guaranteed rights in:

    a. Original Medicare
    b. Medicare Advantage (MA) and other Medicare health plans
    c. Medicare Prescription Drug Plans (PDPs)
    d. All of the above

2. You can file a complaint about:

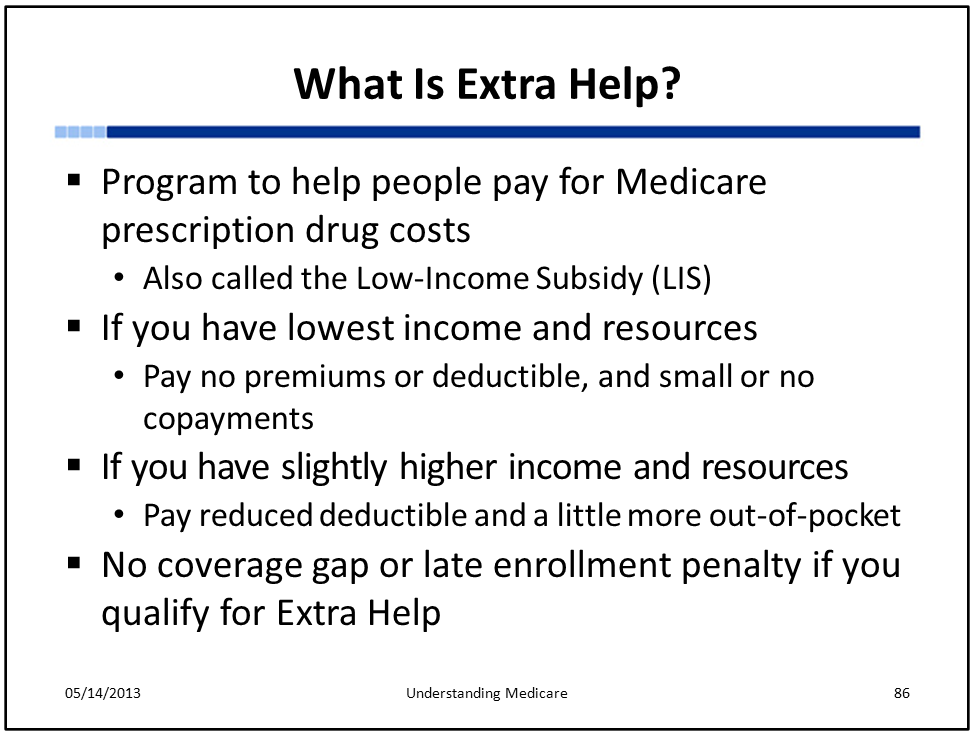
    a. A coverage decision
    b. A payment decision
    c. The quality of the services you received
    d. The health care you received

Refer to page 101 to check your answers.



Lesson 4, *Programs for People With Limited Income and Resources*, explains

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

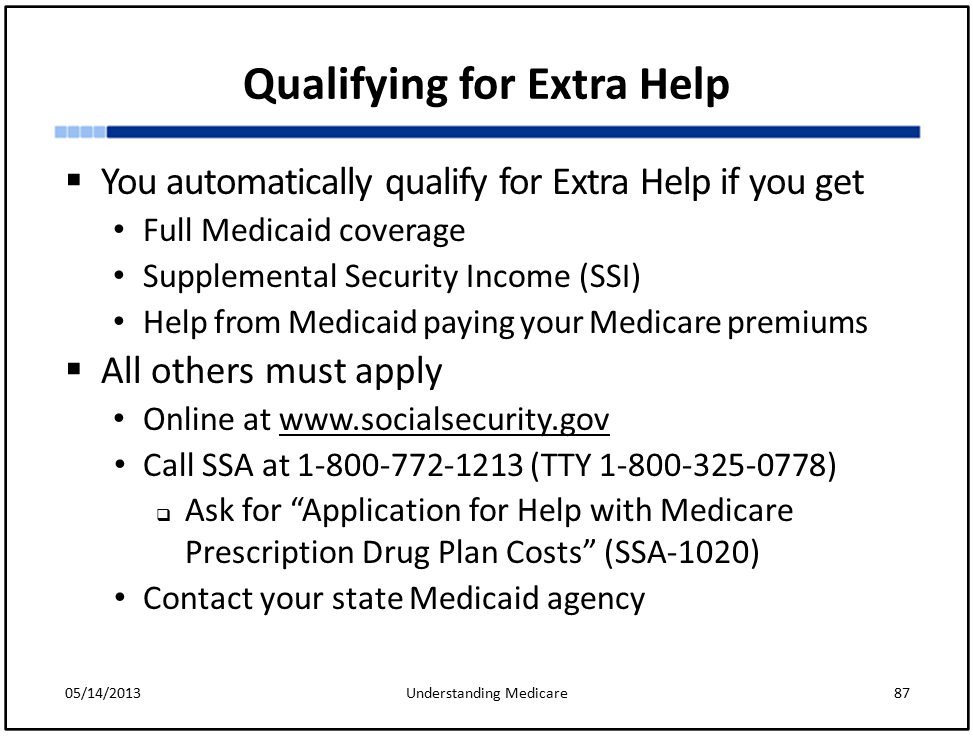


If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. Extra Help is also called the Low-Income Subsidy (LIS).

If you have the lowest income and resources, you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out of pocket.

If you qualify for Extra Help, you won't have a coverage gap or late enrollment penalty. You'll also have a continuous Special Enrollment Period (SEP) and can switch plans at any time, with the new plan going into effect the first day of the next month.

NOTE: Residents of U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.



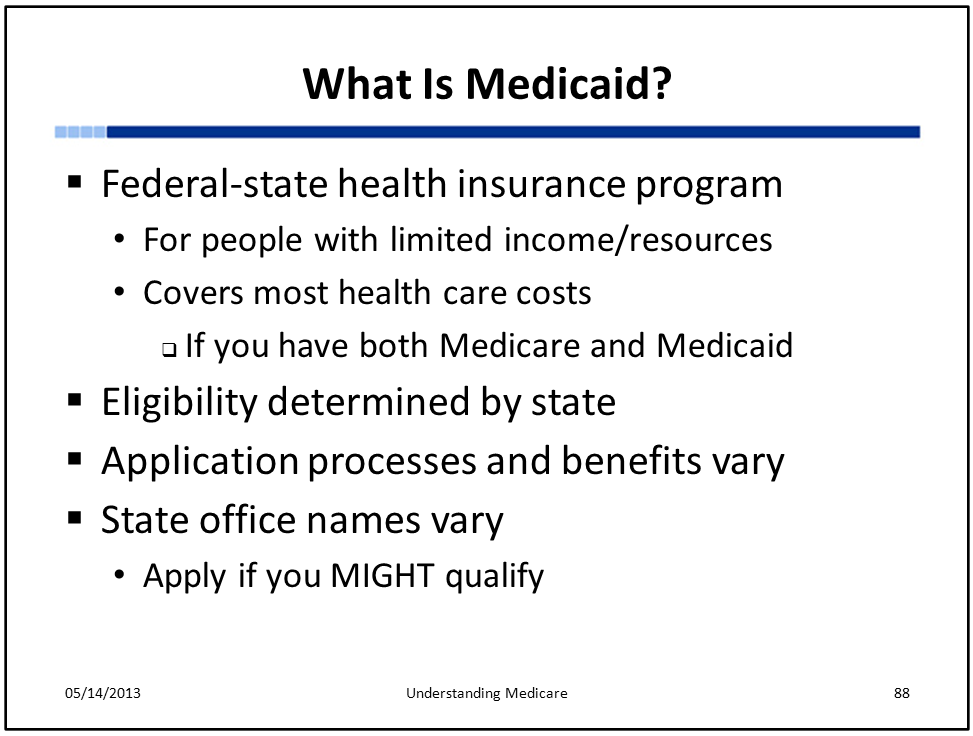
You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income (SSI) benefits, or help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program).

If you don't meet one of the above conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your state Medicaid agency.

You may qualify for Extra Help, also called the Low-Income Subsidy (LIS), if your yearly income and resources are below these limits in 2013:

- **Single person** — Income less than $17,235 and resources less than $13,330; or
- **Married person living with a spouse and no dependents** — Income less than $23,265 and resources less than $26,580.

These amounts may change each year. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). See Appendix C for the 2013 Extra Help income and resource guidelines. You can apply for Extra Help by completing a paper application you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778). You may also apply online at www.socialsecurity.gov, through your state Medicaid agency, or by working with a local organization, such as a State Health Insurance Assistance Program (SHIP).



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 governments and is administered by each state. It can cover pregnant women and children; aged, blind, and disabled people; and some other groups, depending on the state.

If you're eligible for both Medicare and Medicaid, most of your health care costs are covered; we sometimes 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 should contact your state Medical Assistance office to see if you qualify.

You should apply if you think you MIGHT qualify. For more information or to apply, you can

- Call 1-800-MEDICARE;
- Call your State Health Insurance Assistance Program (SHIP); or
- Call or visit your state Medical Assistance office.

Medicare Savings Programs

- Help from Medicaid paying Medicare costs
  - For people with limited income and resources
- Often higher income and resources than full Medicaid
- Programs include
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individual (QI)
  - Qualified Disabled & Working Individuals (QDWI)

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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 full 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. In most cases, to qualify for a Medicare Savings Program in 2013, you must have:

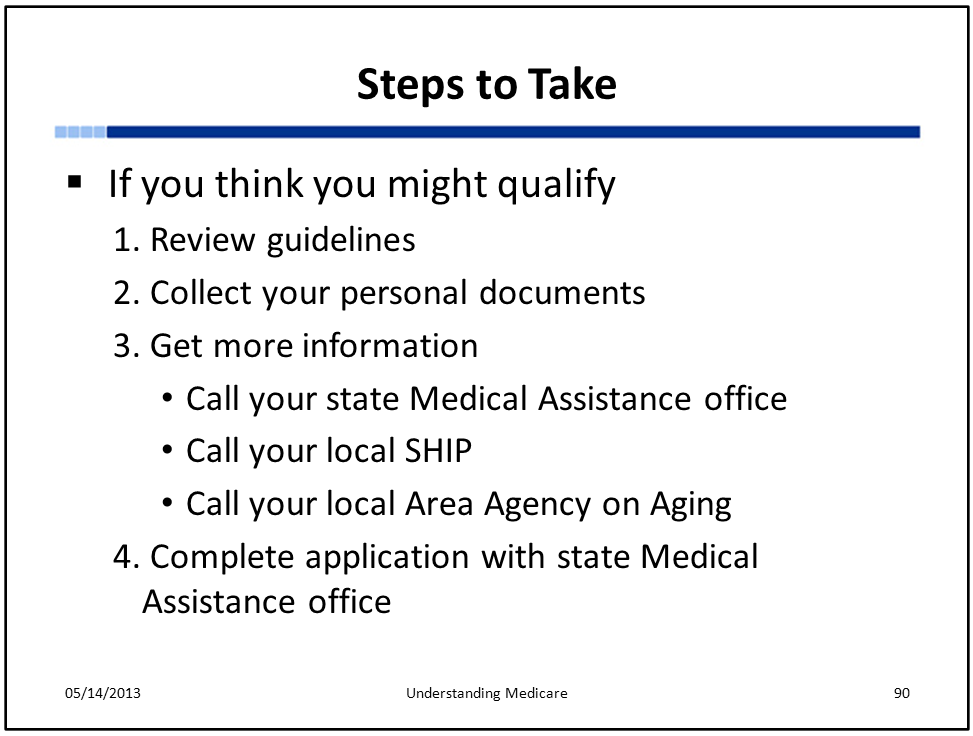
- Part A
- Monthly income less than $1,313 and resources less than $7,080—one person
- Monthly income less than $1,765 and resources less than $10,620— married and living together

Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher than the amounts listed above. If you have income from working, you may qualify for benefits even if your income is higher than the limits above.

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.

Need More Information?

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.

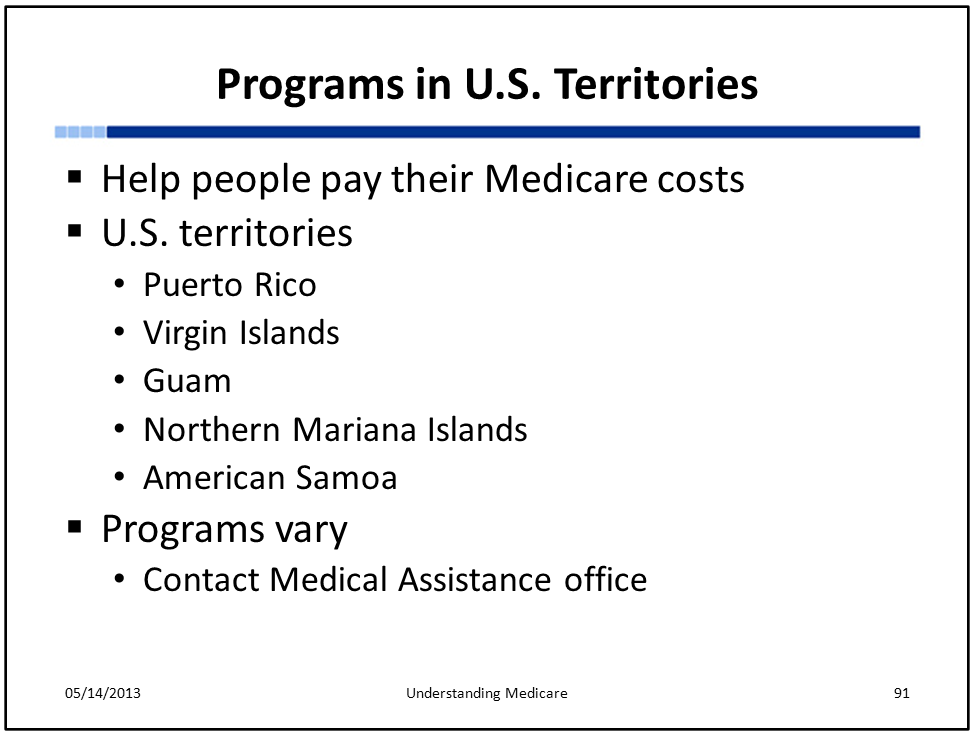
First, review the income and resource (or asset) guidelines for your area.

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

- 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; and
- 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.

Check Your Knowledge
Lesson 4 – Programs for People With Limited Income and Resources

Answer the following questions:

1. Extra Help is a program that helps pay Medicare

   a. Part B premiums
   b. Part A premiums
   c. Part B deductibles
   d. Prescription drug costs

2. True or False: Medicare Savings programs have higher income and resource requirements than full Medicaid.

   a. True
   b. False

Refer to page 102 to check your answers.

Introduction to Medicare Resource Guide

Resources

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.Benefits.gov

http://www.Insurekidsnow.gov

Affordable Care Act
www.healthcare.gov/law/full/index.html

Medicare Products

Medicare & You Handbook
CMS Product No. 10050

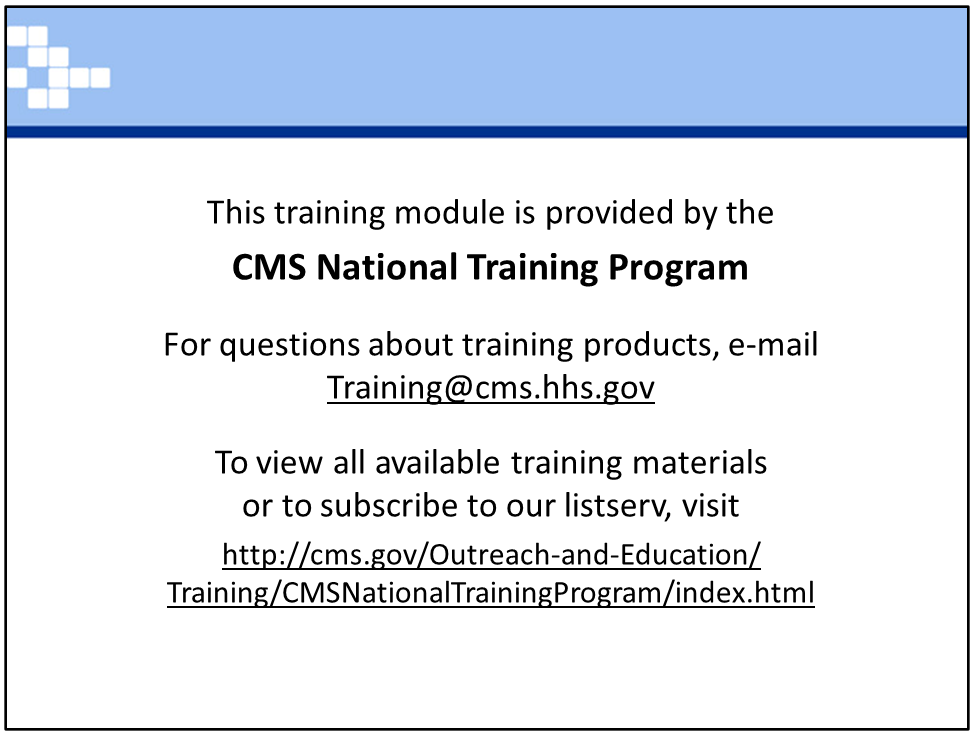
Your Medicare Benefits
CMS Product No. 10116

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.



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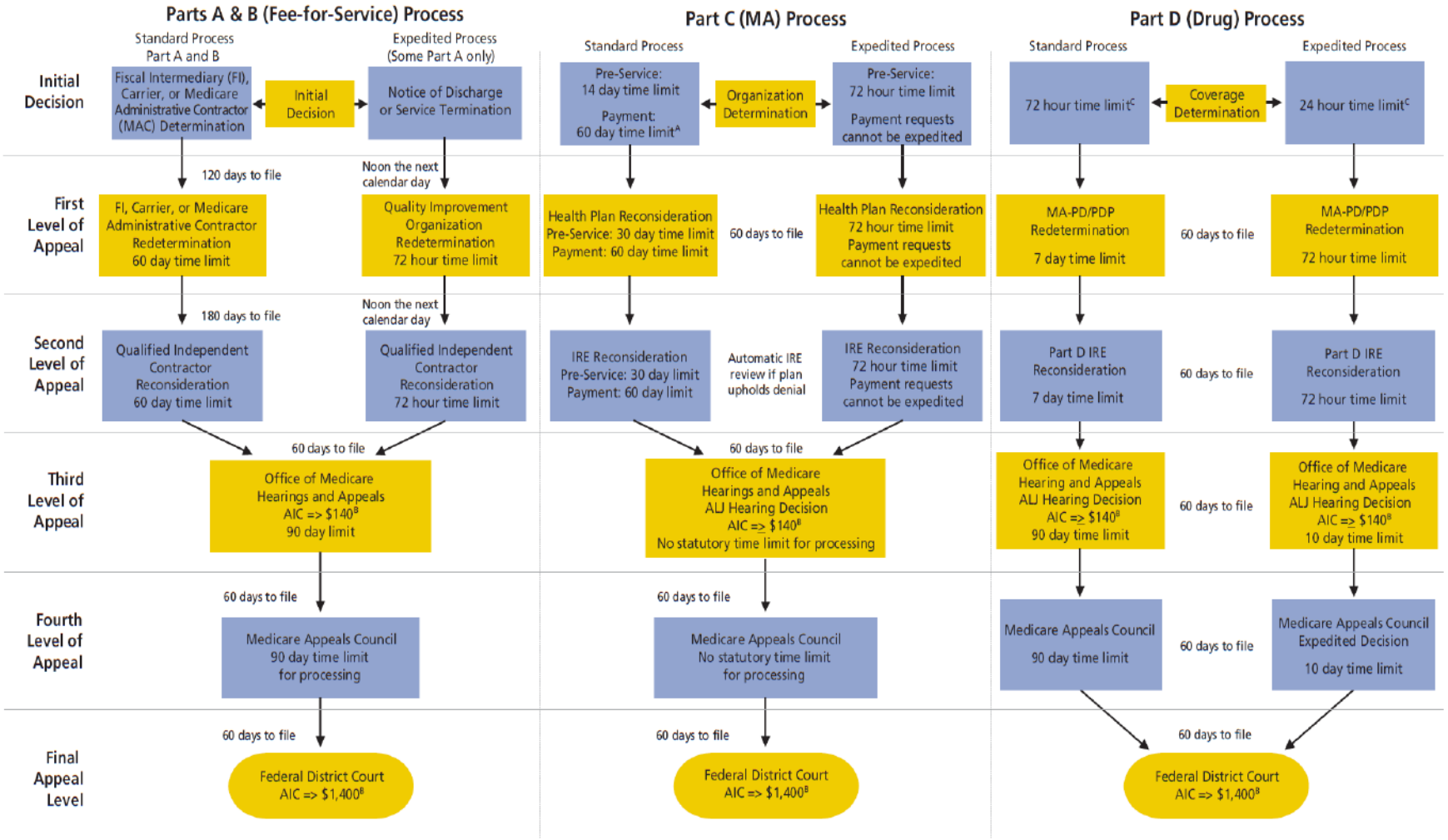
Appendix A: 2013 Standard Drug Benefit

Benefit Parameters	2013	2014
Deductible	$325	$310
Initial Coverage Limit	$2,970.00	$2,850.00
Out-of-Pocket Threshold	$4,750.00	$4,550.00
Total Covered Drug Spending at OOP Threshold	$6,954.52	$6,690.77
Minimum Cost-Sharing in Catastrophic Coverage	$2.65/$6.60	$2.55/$6.35
Extra Help Copayments	**2013**	**2014**
Institutionalized	$0	$0
Receiving Home and Community-Based Services	$0	$0
Up to or at 100% Federal Poverty Level (FPL)	$1.15/$3.50	$1.20/$3.60
Full Extra Help	$2.65/$6.60	$2.55/$6.35
Partial Extra Help (Deductible/Cost-Sharing)	$66/15%	$63/15%

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



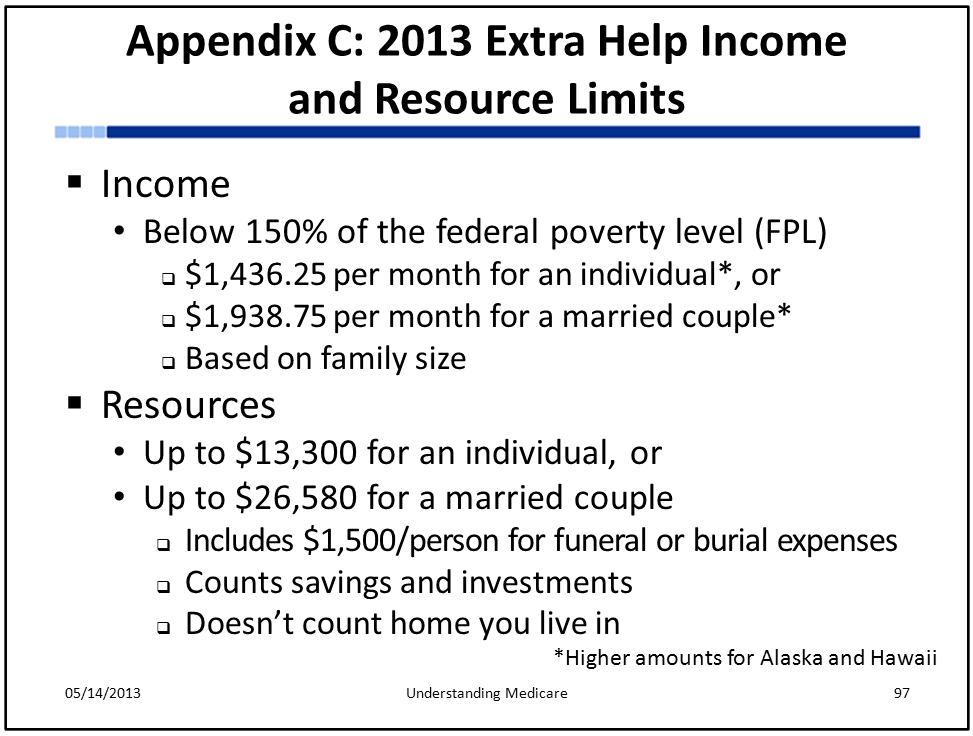
AIC = Amount in Controversy
ALJ = Administrative Law Judge
Contractor = Fiscal Intermediary, Carrier or Medicare Administrative Contractor (MAC)
IRE = Independent Review Entity

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 2013 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.



You may get Extra Help if you have Medicare, income below 150 percent of the federal poverty level (FPL), and limited resources. You may qualify for Extra Help if your income and resources are below the above limits in 2013. These amounts may change in 2014.

If you're married and live with your spouse, both of your incomes and resources count, even if only one of you applies for Extra Help. If you're married and don't live with your spouse when you apply, only your income and resources count. The income is compared to the FPL for a single person or a married person, as appropriate. Whether you and/or your spouse have dependent relatives who live with you and who rely on you for at least half of their support is also taken into consideration. This means that a grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Only two types of resources are used to see if you're eligible for Extra Help:

- Liquid resources (such as savings accounts, stocks, bonds, and other assets that can be changed into cash within 20 days); and
- Real estate, not including your home or the land on which your home is located.

Items such as wedding rings and family heirlooms aren't counted when seeing if you qualify for Extra Help.

NOTE: The income and resource levels listed are for 2013 and can go up each year. Income levels are higher if you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or if you work. Updated resource limits are usually released each fall for the next calendar year. Updated income limits usually are released each February for the same calendar year.

Appendix D: 2013 Medicare Savings Program (MSP) Income/Resource Limits

Medicare Savings Program	Individual Monthly Income Limit*	Married Couple Monthly Income Limit*	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$978	$1,313	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,169	$1,571	Part B premiums only
Qualifying Individual (QI)	$1,313	$1,765	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	$3,915	$5,255	Part A premiums only

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If you qualify for the Qualified Medicare Beneficiary (QMB) program, you get help paying your Part A and Part B premiums, deductibles, co-insurance, and co-pays. To qualify you must be eligible for Medicare Part A and have an income not exceeding 100 percent of the federal poverty level (FPL). This will be effective the first month following the month QMB eligibility is approved (can't be retroactive).

If you qualify for the Specified Low-Income Medicare Beneficiary (SLMB) program, you get help paying for your Part B premium. To qualify you must be eligible for Medicare Part A and have an income that is at least 100 percent, but does not exceed 120 percent of the FPL.

If you qualify for the Qualifying Individual (QI) program, and there are still funds available in your state, you get help paying your Part B premium. It is federally funded. Congress only appropriated a limited amount of funds to each state. To qualify, you must be eligible for Medicare Part A, and have an income not exceeding 135 percent of the FPL.

If you qualify for the Qualified Disabled and Working Individual (QDWI) program, you get help paying your Part A premium. To qualify you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity; have an income not higher than 200 percent of the FPL, and resources not exceeding twice maximum for SSI ($4,000 for an individual and $6,000 for married couple in 2013); and not be otherwise eligible for Medicaid. If you qualify, you get help paying your Part A premium. If your income is between 150 percent and 200 percent of the FPL, the state can ask you to pay a part of the Medicare Part A premium.

In 2013, the resource limits for the QMB, SLMB, and QI programs are $7,080 for a single person and $10,620 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 since September of the previous year.

Check Your Knowledge
Lesson 1 – Program Basics
(*from p. 38*)

Answer the following questions:

1. Medicare Part A helps pay for:

    a. Inpatient hospital stays
    b. Skilled Nursing Facility (SNF) care
    c. Home health care
    d. All of the above

    ANSWER: d. All of the above. (p. 14)

2. If you are under 65 and disabled, you'll automatically get Part A and Part B after you get disability benefits for:

    a. 12 months
    b. 24 months
    c. 36 months
    d. It's not automatic, you must apply

    ANSWER: b. You get Part A and Part B automatically if you are under 65 and disabled if you receive disability benefits from Social Security, or certain disability benefits from the RRB, for 24 months. If you have ALS (Lou Gehrig's Disease), you'll automatically get Part A and Part B the month your disability benefits begin. (p. 6)

Check Your Knowledge
Lesson 2 – Program Basics
(*from p. 72*)

Answer the following questions:

1. Providers and suppliers that don't accept assignment may charge up to:

   a. 10 percent more
   b. 20 percent more
   c. 15 percent more
   d. An unlimited amount more

   ANSWER: c. Providers and suppliers can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge" or "excess charge." The provider can only charge you up to 15 percent over the amount that non-participating providers are paid. (p. 42)

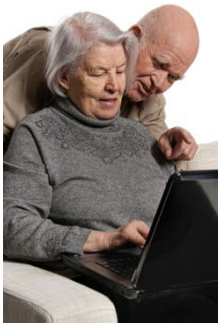
2. True or False: Everyone with a Part D plan pays the same premium.

   a. True
   b. False

   ANSWER: b. False. Different plans charge different premiums. Also, some people may pay a higher premium based on their income. This is called the Part D IRMAA. (p.59, 62)

Check Your Knowledge
Lesson 3 – Rights and the Appeals Process
(*from p. 84*)

Answer the following questions:



1. You have guaranteed rights in:

    a. Original Medicare
    b. Medicare Advantage (MA) and other Medicare health plans
    c. Medicare Prescription Drug Plans (PDPs)
    d. All of the above

    ANSWER: d. All of the above. (p. 74)

2. You can file a complaint about:

    a. A coverage decision
    b. A payment decision
    c. The quality of the services you received
    d. The health care you received

    ANSWER: c and d. You can file a complaint (sometimes called a grievance) based on concerns or problems you may have had in getting health care or the quality of the health care received. (p. 77)

Check Your Knowledge
Lesson 4 – Programs for People With Limited Income and Resources
(from p. 92)

Answer the following questions:

1. Extra Help is a program that helps pay Medicare:

   a. Part B premiums
   b. Part A premiums
   c. Part B deductibles
   d. Prescription drug costs

   ANSWER: d. Extra Help is a program that helps pay Medicare prescription drug costs. (p. 86)

2. True or False: Medicare Savings programs have higher income and resource requirements than full Medicaid.

   a. True
   b. False

   ANSWER: a. True. Medicare Savings programs have higher income and resource requirements than full Medicaid. (p. 89)

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ALS	Amyotrophic Lateral Sclerosis (also known as Lou Gehrig's Disease)
BPH	Benign Prostatic Hyperplasia
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPI	Consumer Price Index
CT	Computed Tomography
DME	Durable Medical Equipment
EKG	Electrocardiogram
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FPL	Federal Poverty Level
GEP	General Enrollment Period
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HMOPOS	HMO Point-of-Service
IEP	Initial Enrollment Period
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
LIS	Low-Income Subsidy
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Account
MSN	Medicare Summary Notice
OEP	Open Enrollment Period
OPM	Office of Personnel Management
PACE	Programs of All-inclusive Care for the Elderly
PDP	Prescription Drug Plan

PFFS	Private Fee-for-Service
PPO	Preferred Provider Organization
QDWI	Qualified Disabled & Working Individuals
QI	Qualifying Individual
QMB	Qualified Medicare Beneficiary
RRB	Railroad Retirement Board
SEP	Special Enrollment Period
SGA	Substantial Gainful Activity
SHIP	State Health Insurance Assistance Program
SLMB	Specified Low-income Medicare Beneficiary
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TTY	Teletypewriter

Inside back cover

Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram

E-mail training@cms.hhs.gov

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