Module 1 – Understanding Medicare

Section Objectives

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

Lesson 1: Program Basics

What is Medicare?

Medicare currently provides health insurance coverage for 57.7 million U.S. citizens. That's approximately 1 in every 6 Americans.

- Medicare is health insurance for generally 3 groups of people:
  - Those who are 65 and older
  - People under 65 with certain disabilities who've been entitled to Social Security disability benefits for 24 months—includes ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), without a waiting period
  - People of any age who have End-Stage Renal Disease (ESRD), which is permanent kidney failure that requires a regular course of dialysis or a kidney transplant
- The Centers for Medicare & Medicaid Services administers the Medicare Program.

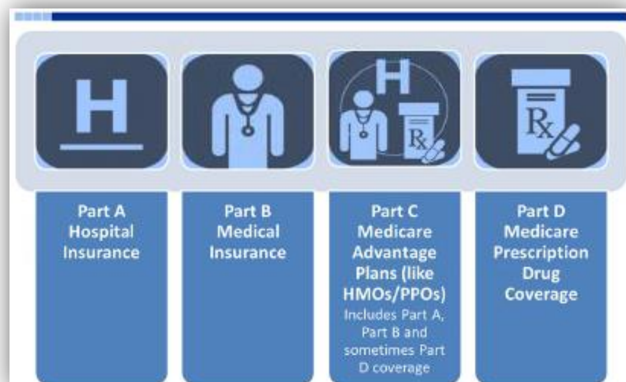
NOTE: To get Part A and/or Part B, you must be a U.S. citizen or be lawfully present* in the United States. If you live in Puerto Rico, you must actively enroll in Part B.

**Lawfully present means you're in the U.S. legally, and includes non–U.S. citizens who have permission to live and/or work in the U.S.*

***Resource**: "Medicare & You" handbook (Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf)*

Four Parts of Medicare

Medicare covers many types of services, and you have options for how to you get your Medicare coverage. Medicare has 4 parts:



- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.

- **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 like wheelchairs and walkers. Together, Part A and Part B are also referred to as "Original Medicare."
- **Part C (Medicare Advantage [MA])** is another way to get your Medicare benefits. It combines Part A and Part B, and sometimes Part D (prescription drug coverage). 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. Part D may help lower your prescription drug costs and protect you against higher costs in the future.

Automatic Enrollment – Parts A and B

If you're already getting Social Security benefits (for example, getting early retirement at least 4 months before you turn 65), you'll be automatically enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the first day of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

If you're not getting retirement benefits from Social Security or the Railroad Retirement Board (RRB), you must sign up to get Medicare.

NOTE: If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65, or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it. If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Contact your local Social Security office or the RRB for more information.

"Welcome to Medicare," CMS Product No. 11095, is pictured on this page. It's part of the Initial Enrollment Period package. Visit Medicare.gov/Pubs/pdf/11095.pdf.

Medicare Card

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 type of Medicare coverage (Part A and/or Part B) you have and the date the coverage started. Your card may look slightly different from this one; it's still valid.

The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals indicate 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 "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 get your Medicare card in your Initial Enrollment Period package and keep it, you keep Part B and will pay the Part B premium (unless Medicaid pays your premium). If you don't want Part B, and decide to enroll later, you'll likely pay a late enrollment penalty. If you don't want Part B, follow the directions on the back of the card, and return it. We'll describe reasons why you might want to delay taking Part B later in this presentation. If you choose a Medicare health plan, your plan will likely give you a card to use when you get health care services and supplies.

The Medicare Access and CHIP Reauthorization Act of 2015 requires us to remove Social Security Numbers from all Medicare cards. The work is underway and more information will be available later. You can visit, CMS.gov/medicare/ssnri/ for information about this initiative.

NOTE: Social Security has an online service that lets you get a replacement Medicare card if your old one is lost or needs to be replaced. To create your account and learn more about "mySocialSecurity" accounts, visit SSA.gov/myaccount.

When Enrollment Isn't Automatic

If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A and Part B (even if you're eligible to get Part A 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. You don't have to be retired to get Medicare.

Full retirement age (also called “normal retirement age”) had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959.

The 1983 Social Security Amendments included a provision for raising the full retirement age beginning with people born in 1938 or later. Congress cited improvements in the health of older people and increases in average life expectancy as primary reasons for increasing the normal retirement age.

For more information or to calculate your age for collecting full Social Security retirement benefits, visit SSA.gov/retirement/ageincrease.htm.

NOTE: Although the age to receive full Social Security retirement benefits is increasing, Medicare benefit eligibility due to age still begins at 65.

When to Enroll in Medicare

Your first opportunity to enroll in Medicare is during your Initial Enrollment Period (IEP), which lasts 7 months. Your coverage starts based on when you enroll. If you enroll during the first 3 months of your IEP (the 3 months before the month you turn 65), your coverage will begin the first day of the month you turn 65. If you enroll the month you turn 65, your coverage will begin the first day of the next month. If you enroll in the last 3 months of your IEP (the 3 months after you turn 65), your coverage will begin 2 to 3 months after you turn 65.

If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods.

For everyone (whether you get premium-free Part A or have to pay a premium for it), you can only enroll in Part B during

- Your IEP
- The annual General Enrollment Period (GEP) January 1–March 31 each year
- In limited situations, a Special Enrollment Period (SEP)

If you don't enroll in Part B (or premium Part A) during your IEP, you may have to pay a penalty. For Part B, it's a lifetime penalty for as long as you have Part B.

General Enrollment Period (GEP)

If you didn’t sign up for Part B (or premium Part A) during your Initial Enrollment Period (IEP), you can enroll during the General Enrollment Period (GEP).

The GEP occurs January 1 through March 31 each year. If you enroll in the GEP, your coverage will begin July 1.

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%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up.

Generally, if you don't take Part B when you're first eligible and more than 12 months have passed since you turned 65, you'll likely have to pay a penalty that is added to your monthly Part B premium. The Part B penalty is 10% for each full 12-month period you could've had Part B, but didn't sign up for it. In most cases you'll have to pay this penalty for as long as you have Part B.

Premium Part A and Part B Special Enrollment Period (SEP)

There are very few Special Enrollment Periods (SEPs) for Part B and premium Part A allowed by law. Most people don't qualify for an SEP. However, if you're still working, you may be eligible.

The SEP allows you to enroll after your Initial Enrollment Period (IEP) and not wait for the General Enrollment Period (GEP), and you won't have to pay a penalty.

To be eligible, you must have employer group health plan (EGHP) coverage based on active, current employment. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a member's current employment. People who get Medicare based on end-stage renal disease don't qualify for an SEP.

You must have this EGHP coverage for all the months you were eligible to enroll in Part B, but didn't. For most people, this means you had EGHP coverage since you turned 65.

If you're eligible, you can enroll using the SEP at any time while you have EGHP coverage based on active, current employment. If you lose either the EGHP coverage or the current employment, you'll have 8 months to enroll. If you don't enroll within the 8 months, you'll have to wait until the next GEP to enroll, you'll have a gap in your coverage, and you may have to pay a penalty.

It's important to note that Consolidated Omnibus Budget Reconciliation Act (COBRA), retiree coverage, long-term worker's compensation, or Veterans Affairs coverage isn't considered active, current employment.

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

When Employer or Union Coverage Ends

When your employment ends and you aren't 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 to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month Special Enrollment Period (SEP), you may have to pay a late enrollment penalty and you'll have to wait until the next General Enrollment Period to enroll.

Medicare doesn't pay all health care costs. One way to cover the costs, or "gaps," is to purchase a Medicare Supplement Insurance (Medigap) policy. We'll discuss these policies 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.

Medicare Part A – Hospital Insurance Coverage

Medicare Part A (Hospital Insurance) helps cover medically necessary inpatient services.

- Hospital inpatient care–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit).
- Inpatient skilled nursing facility (SNF) care (not custodial or long-term care) under certain conditions.
- Blood— In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker.
- Home health care—A doctor, or certain health care providers who work with the doctor, must see you face-to-face to certify that you need home health services. You must be homebound, which means that leaving home is a major effort.
- Hospice care—Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; as well as services Medicare usually doesn't cover, such as grief counseling.

NOTE: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the United States. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated.

Paying for Medicare Part A

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. Federal Insurance Contributions Act (FICA) tax is a United States federal payroll (or employment) tax imposed on both employees and employers to fund Social Security and Medicare.

About 99% of people with Medicare don't pay a Part A premium since they've at least 40 quarters of Medicare-covered employment. Enrollees 65 and over and certain persons with disabilities who have fewer than 40 quarters of coverage pay a monthly premium to receive coverage under 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.
- Under 65, have a disability, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and have a disability, you may 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. Social Security determines if you have to pay a monthly premium for Part A. In 2017, the Part A premium for a person who has worked less than 30 quarters of Medicare covered employment is $413 per month. Those who have between 30 and 39 quarters of coverage may buy Part A at a reduced monthly premium rate, which is $227 for 2017.

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% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could've 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. TTY:1-800-325-0778.

Inpatient Hospital Care

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.

Medicare covers certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs). Medicare will only cover the inpatient, non-religious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like un-medicated wound dressings or use of a simple walker. Medicare doesn't cover the religious portion of RNCHI care. Medicare Part A (Hospital Insurance) covers inpatient, non-religious, nonmedical care when certain conditions are met.

NOTE: Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you've not been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility. For more information, read "Are You a Hospital Inpatient or Outpatient?" at Medicare.gov/Pubs/pdf/11435.pdf.

Benefit Periods

A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care or SNF care for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. You must pay the Part A inpatient hospital deductible ($1,260 in 2015) for each benefit period. There is no limit to the number of benefit periods you can have.

Examples:

- You spend 5 days in the hospital. You then enter a SNF for 20 days of rehabilitation. You then return home. Your benefit period will end when you've been out of the SNF for 60 days, or 85 days after you first entered the hospital. If you don't return to the hospital as an inpatient in that time frame, you'll pay another deductible for the next benefit period.
- You've returned home after being an inpatient in the hospital or of a combination of hospital and a SNF. After 2 weeks at home you must return to the hospital. You haven't been out of inpatient care for 60 days, so you're still in your first benefit period. You don't have to pay another hospital deductible.

NOTE: To qualify for post-hospital extended care services (i.e. SNF) you must been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. 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.

Paying for Inpatient Hospital Stays

For Each Benefit Period in 2017	You Pay
Days 1-60	$1,316 deductible
Days 61-90	$329 per day
Days 91-150	$658 per day (60 lifetime reserve days)
All days after 150	All Costs

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

Skilled Nursing Facility – Covered Services

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
- Dietary counseling

Skilled Nursing Facility (SNF) Care Required Conditions

Part A will pay for skilled nursing facility (SNF) care if you meet the following conditions:

- Your doctor must certify that your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a SNF.
    - This doesn't 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 before you were admitted to a participating SNF. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in 1 or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. 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.
- 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.

For more information, read "Medicare Coverage of Skilled Nursing Facility Care" at Medicare.gov/Pubs/pdf/10153.pdf.

Paying for Skilled Nursing Facility Care

For Each Benefit Period in 2017	You Pay
Days 1-20	$0
Days 21-100	$164.50 per day
All days after 100	All Costs

Five Conditions for Home Health Care

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

1) You must be homebound. An individual shall be considered "confined to the home" (homebound) if the following 2 criteria are met: 1) The patient must either, because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, OR 2) have a condition such that leaving his or her home is medically contraindicated. If the patient meets only 1 of the 2 previous conditions, then the patient must ALSO meet the these 2 additional requirements: 1) There must exist a normal inability to leave home, AND 2) Leaving home must require a considerable and taxing effort.
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 other health care provider 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 health care provider in a location different from 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 doesn't precede the need for home health care, or when the number of Part A covered home health care visits exceed 100. For more information, read "Medicare and Home Health Care," at Medicare.gov/Pubs/pdf/10969.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHACenter.html.

Paying for Home Health Care

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.

Durable medical equipment, when ordered by a doctor, is paid separately by Medicare. This equipment must meet certain criteria to be covered. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home. To find a home health agency in your area, visit Medicare.gov and use the Home Health Compare tool, or call 1-800-MEDICARE (1-800-633-4227). TTY: 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 Hospice Care

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 an election 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're terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "election 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 also requires face-to-face visits. The doctor is required to meet with you within 30 days of hospice recertification, starting before the third election period and each subsequent recertification.

The hospice provider must be Medicare-approved.

For more information, read "Medicare Hospice Benefits" at Medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF.

Covered Hospice Services

In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech language therapy, the hospice benefit also covers

- Medical equipment (such as wheelchairs or walkers).
- Medical supplies (such as bandages and catheters).
- Drugs for symptom control and pain relief.
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management.
- Inpatient respite care, which is care given to 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.
- Other covered services as well as services Medicare usually doesn't cover, like spiritual and grief counseling.
- Dietary and other counseling.

Paying for Hospice Care

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 while receiving routine or continuous care at home, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'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.

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227), or your state hospice organization. TTY: 1-877-486-2048.

For more information, visit the "Medicare Benefit Policy Manual," Chapter 9, Coverage of Hospice Services under Hospital Insurance at www.CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf.

Medicare Part B – Medical Insurance Coverage

Medicare Part B (Medical Insurance) helps cover medically necessary outpatient services and supplies.

- Doctors' services—Services that are medically necessary.
- Outpatient medical and surgical services and supplies— For approved procedures like X-rays or stitches.
- Clinical laboratory services—Blood tests, urinalysis, and some screening tests.
- Durable medical equipment like walkers and wheelchairs—You may need to use certain suppliers under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program. Visit Medicare.gov/supplierdirectory/.
- Diabetic testing supplies— You may need to use specific suppliers for some types of diabetic testing supplies.
- Preventive services—Exams, tests, screening and shots to prevent, find, or manage a medical problem.

What Are Medicare Part B – Covered Services

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% 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% 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% 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 has 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. This includes mail-order diabetic self-testing supplies, insulin pumps, and pump supplies.

The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts under the DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program at least once every 3 years. The Round 2 and national mail-order program contract periods expire on June 30, 2016. Round 2 re-compete and the national mail-order re-compete contracts are scheduled became effective on July 1, 2016, and will expire on December 31, 2018.

The national mail-order re-compete competitive bidding area includes all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

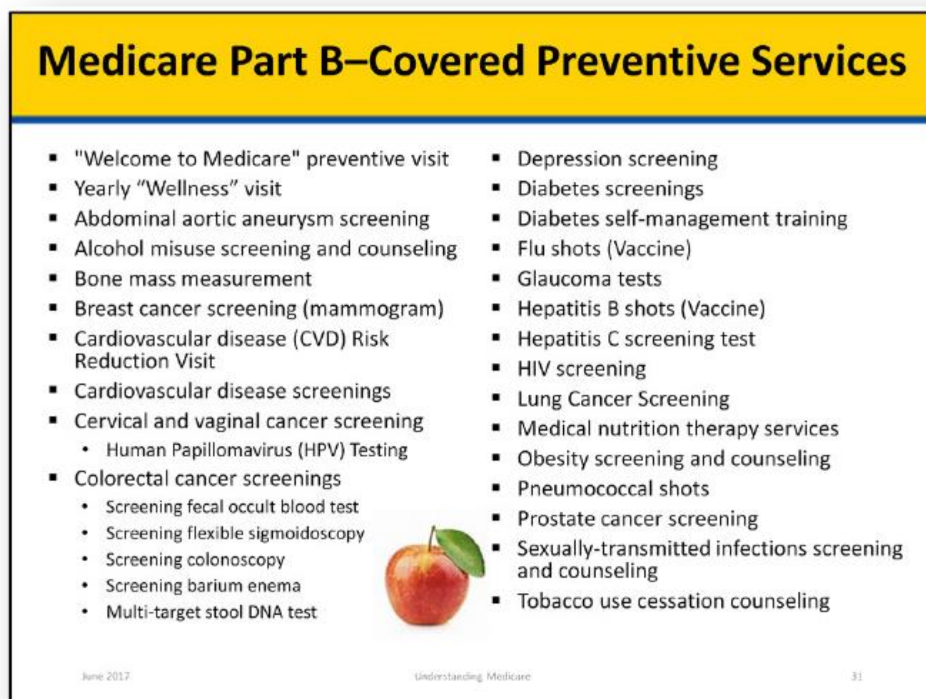
If you need DME or supplies, visit Medicare.gov/supplier to find Medicare-approved suppliers. If your ZIP Code is in a competitive bidding area, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. For more information on the competitive bidding program, you can visit: CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.

Home Health 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, and medical supplies for use at home. You must be homebound, as defined previously. You pay nothing for covered home health services.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit 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. For more information on Part B coverage, visit Medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html.

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.

Medicare Part B – Covered Preventive Services



Paying for Part B Services

Under Original Medicare you'll pay nothing for most preventive services if you get the services from a doctor or other provider who accepts assignment.

Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services, and not to bill you for any more than the Medicare deductible and coinsurance.

You'll pay nothing for certain preventive services. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under the preventive benefits, you may have to pay a copayment, and the Part B deductible may apply. Later, we'll discuss which preventive services require a copayment.

Section 4104 of the Affordable Care Act waived deductibles, copayments, or coinsurance effective for date of service or after January 1, 2011, for the following Medicare-covered preventive services:

- The Initial Preventive Physical Examination (IPPE) or ("Welcome to Medicare" preventive visit)
- The yearly "Wellness" visit
- Those preventive services that are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population and are appropriate for the person with Medicare.
-

For more information on Medicare-covered preventive services, visit Medicare.gov/coverage/preventive-and-screening-services.html.

NOT Covered by Part A and Part B

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.

Medicare doesn't cover long-term care. Long-term care includes medical and nonmedical 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.

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

For more information about what isn't covered by Medicare, visit Medicare.gov/what-medicarecovers/not-covered/item-and-services-not-covered-by-part-a-and-b.html.

Medicare Part B Costs for Most People

Yearly Deductible	$183.00
Coinsurance for Part B Services	▪ 20% coinsurance for most covered services, like doctor's services and some preventive services, if provider accepts assignment ▪ $0 for some preventive services ▪ 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services

What You Pay – Part B Premiums

You pay a premium for Part B each month. The standard Part B premium amount in 2017 is $134 (or higher depending on your income). However, most people who get Social Security benefits will pay less than this amount. This is because the Part B premium increased more than the cost-of-living increase for 2017 Social Security benefits. If you pay your Part B premium through your monthly Social Security benefit, you'll pay less ($109 on average). Social Security will tell you the exact amount you will pay for Part B.

REMEMBER: 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% for each 12-month period that you could have had Part B but didn't take it. An exception would be if you can enroll in Part B during a Special Enrollment Period because 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.

Those who'll pay the standard premium ($134.00 or higher) in 2017 include people in one of these 5 groups:

- You enroll in Part B for the first time in 2017
- You don't get Social Security benefits
- You're directly billed for your Part B premiums
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $134.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount. If so, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

Chart is based on your yearly income *in 2015* (for what you pay in 2017)			
File Individual Tax Return	**File Joint Tax Return**	**File Married & Separate Tax Return**	**In 2017 You Pay**
$85,000 or less	$170,000 or less	$85,000 or less	$134.00
$85,000.01–$107,000	$170,000.01–$214,000	Not applicable	$187.50
$107,000.01–$160,000	$214,000.01–$320,000	Not applicable	$267.90
$160,000.01–$214,000	$320,000.01–$428,000	Above $85,00 and up to $129,000	$348.30
Above $214,000	Above $428,000	Above $129,000	$428.60

NOTE: You may pay more if you have a Part B late enrollment penalty.

Paying the Part B Premium

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 Social Security, the Railroad Retirement Board or the Office of Personnel Management 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.

Part B Late Enrollment Penalty

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 that 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% for each full 12-month period you could've 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 a Special Enrollment Period (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 a SEP. This SEP doesn't apply to people with End-Stage Renal Disease.

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's Initial Enrollment Period ended September 30, 2009. She waited to sign up for Part B until the General Enrollment Period in March 2012.

- Total time Mary delayed Part B: 30 month
- Mary's Late Enrollment Penalty: 20% (30 months includes 2 full 12-month periods)
- The penalty is added to the Part B monthly premium
- Mary will have the penalty for as long as she has Part B

When You Must Have Part B

You must have Part B if

- You want to buy a Medicare Supplement Insurance (Medigap) policy
- You want to join a Medicare Advantage Plan
- You're eligible for TRICARE for Life (TFL)* or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Your employer coverage requires you or your spouse/family member to have it when you become eligible for Medicare —less than 20 employees (talk to your employer's or union benefits administrator)

Veterans Affairs (VA) benefits are separate from Medicare. With VA benefits, you may choose to not enroll in Part B, but you pay a penalty if you don't sign up for Part B during your Initial Enrollment Period (visit VA.gov). If you have VA coverage, you won't be eligible to enroll in Part B using the Special Enrollment Period (SEP).

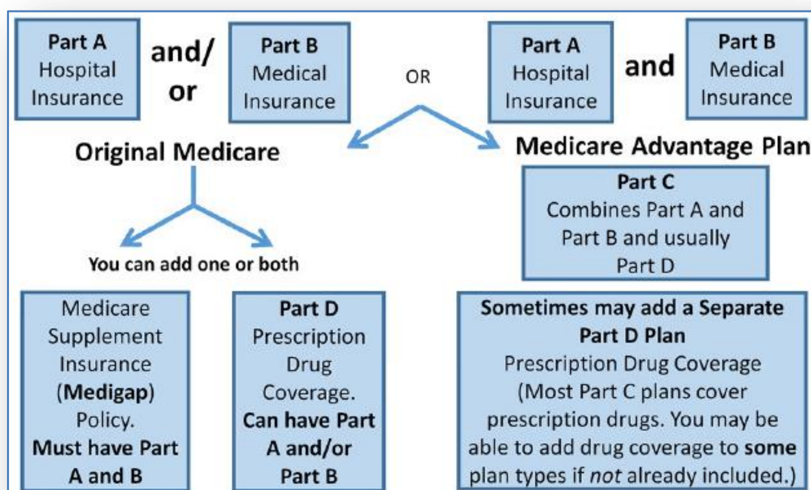
*TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You must have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) to get TFL benefits. However, if you're an active-duty service member, or the spouse or dependent child of an active-duty service member, you don't have to enroll in Part B to keep your TRICARE coverage. When the active-duty service member retires, you must enroll in Part B to keep your TFL coverage. You can get Part B during a Special Enrollment Period if you have Medicare because you're 65 or older, or you're disabled. For more information, visit Tricare.mil/mybenefit.

You must have Part A and Part B to keep your CHAMPVA coverage.

NOTE: See also Medicare.gov/Pubs/pdf/02179.pdf for more information on “Who Pays First.”

Lesson 2: Medicare Coverage Choices

Medicare Coverage Choices



Medigap policies don’t work with these plans. If you join a Medicare Advantage Plan, you can’t use a Medicare Supplement Insurance (Medigap) Policy to pay for out-of-pocket costs while you are enrolled in an MA Plan.

Original Medicare

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 Plan or other Medicare health plan. Original Medicare is a fee-for-service program that’s 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 for those not “held harmless” is $134 in 2017.

In Original Medicare, you also pay deductibles, 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 (Part D) to add drug coverage.

Assignment

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
- 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.

Don't Accept/Must Accept Assignment

"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. 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: 1-877-486-2048. In some cases, you might have to submit your own claim to Medicare using form CMS-1490S to get paid back. Visit 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% over the amount that non-participating providers are paid. Non-participating providers are paid 95% 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.

To find out if your doctors, suppliers, and other health care providers accept assignment or participate in Medicare, visit www.Medicare.gov/physician or 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: 1-877-486-2048.

Ambulance suppliers must accept assignment. For more information on ambulance coverage, visit Medicare/gov/coverage/amubulance-services.html.

Private Contracts

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 Medicare Supplement Insurance (Medigap) Policies won't 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, won't pay anything for the service.
- You'll have to pay whatever this doctor or provider charges you. (The Medicare limiting charge won't apply.)
- Other Medicare plans won't pay for the services.
- No claim should be submitted, and Medicare won't pay if one is submitted.
- Many other insurance plans won't pay for the service either.
- The doctor can't bill Medicare for 2 years for any services provided to anyone with Medicare.

Medicare Supplement Insurance (Medigap) Policies

A Medicare Supplement Insurance policy (often called Medigap) is private health insurance that's designed to supplement Original Medicare.

This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). These are "gaps" in Medicare coverage. If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share.

- You must have both Medicare Part A and Part B to get a Medigap policy.
- You pay the private insurance company a monthly premium for your Medigap policy in addition to your monthly Part B premium.

Medigap policies cover only one person. If you and your spouse both want Medigap coverage, you'll need to have separate Medigap policies.

NOTE: Module 3, "Medigap (Medicare Supplement Insurance)" describes this topic in more detail at cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS026529.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending.html.

Medigap Plans

In most states, Medigap insurance companies can only sell you a standardized Medigap policy identified by letters A, B, C, D, F, G, K, L, M, and N. Plans D and G with an effective date on or after June 1, 2010, have different benefits than Plans D and G bought before June 1, 2010. Plans E, H, I, and J are no longer sold, but, if you already have one, you can generally keep it. Plan F has a high-deductible option.

Each standardized Medigap plan must offer the same basic benefits, no matter which insurance company sells it. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from. Cost is usually the only difference between Medigap policies with the same letter sold by different insurance companies. You're encouraged to shop carefully for a Medigap policy.

Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap plan, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies may be available in your state. If you need more information, call your State Insurance Department or State Health Insurance Assistance Program. You can find their contact information at Medicare.gov/contacts.

Some people may still have a Medigap policy they purchased before the plans were standardized. If they do, they can keep these plans. If they drop them, they may not be able to get them back.

Medigap policies are standardized in a different way in Massachusetts, Minnesota, and Wisconsin. These are called waiver states.

NOTE: See "Medicare Supplement Insurance (Medigap) Policies," Module 3 for more information at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

Medigap Policies

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, your age, and location.

Must follow federal and state laws that protect people with Medicare.

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

- Use medical underwriting (a process insurance companies use to decide, based on your medical history, whether to accept your application for insurance, whether to add a waiting period for pre-existing conditions, and how much to charge you.)
- Refuse to sell you any Medigap policy it offers
- Charge you more for a Medigap policy than they charge someone with no health problems
- Make you wait for coverage to start (except in certain pre-existing circumstances)

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

Medigap policies don't work with Medicare Advantage Plans.

Medigap policies 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.

Delayed Medigap Open Enrollment Period (OEP)

If you have group health coverage through an employer or union because either you or your spouse is currently actively working, you may want to wait to enroll in Medicare Part B. This is because

- Benefits based on current employment often provide coverage similar to Part B.
- You would be paying for Part B before you need it.
- Your Medigap Open Enrollment Period (OEP) might expire before a Medigap policy would be useful.

When the employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty, which means your Medigap OEP will start when you're ready to take advantage of it. If you enroll in Part B while you still have current employer coverage, your Medigap OEP will start, and unless you buy a Medigap policy before you need it, you'll miss your OEP entirely. If you or your spouse is still working and you have coverage through an employer, contact your employer or union benefits administrator to find out how your insurance works with Medicare.

If you aren't going to enroll in Part B due to current employment, it's important that you notify Social Security that you want to delay Part B.

NOTE: Remember, if you took Part B while you had employer coverage, you don't get another Medigap OEP when your employer coverage ends. You must have both Medicare Part A and Medicare Part B to buy a Medigap policy.

Pre-Existing Conditions and Medigap

The insurance company may be able to make you wait for coverage related to a pre-existing condition (i.e. a health problem you have before the date a new insurance policy starts) for up to 6 months. This is called a "pre-existing condition waiting period." After 6 months, the Medigap policy will cover the pre-existing condition.

Coverage for a pre-existing condition can only be excluded in a Medigap policy if the condition was treated or diagnosed within 6 months before the date the coverage starts under the Medigap policy. This is called the "look-back period." Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket costs. You're responsible for the Medicare coinsurance or copayment.

If you buy a Medigap policy during your Medigap Open Enrollment Period, and you're replacing certain kinds of health coverage that count as "creditable coverage" (generally any other health coverage you recently had before applying for a Medigap policy), it's possible to avoid or shorten this waiting period. If you had at least 6 months of continuous prior creditable coverage (with no break in coverage for more than 63 days), the Medigap insurance company can't make you wait before it covers your pre-existing conditions. You can learn more about creditable coverage by reviewing the Code of Federal Regulations, 45 CFR 146.113 at ecfr.gov/cgi-bin/ECFR?page=browse.

If you buy a Medigap policy when you have a guaranteed issue right, the insurance company can't use a pre-existing condition waiting period.

> The Affordable Care Act doesn't impact the pre-existing condition waiting period for Medigap coverage.

Medigap for People With a Disability or End-Stage Renal Disease (ESRD)

If you're under 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD), you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under 65 and eligible for Medicare coverage due solely to ESRD.

Some insurance companies may voluntarily sell Medigap policies to people under 65, although they'll probably cost you more than Medigap policies sold to people over 65, and they can use medical underwriting. Check with your State Insurance Department about state-specific requirements and what rights you might have under state law.

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

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

What's Medicare Prescription Drug Coverage (Part D)

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 drug plan. To get coverage, you must join a plan – enrollment isn't automatic for most people.

There are 2 main ways to get Medicare prescription drug coverage:

1) Join a Medicare Prescription Drug Plan (PDP). These plans add coverage to Original Medicare, and may be added to some other types of Medicare health plans (but not to Medicare Advantage [MA] Plans).
2) Join an MA Plan with prescription drug coverage (MA-PD) (like a Health Maintenance Organization or a Preferred Provider Organization) or another Medicare health plan, like a Medicare Cost Plan that includes Medicare prescription drug coverage. You'll get all your Medicare coverage (Part A and Part B), and your prescription drug coverage (Part D) through these plans.

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

NOTE: Some Medicare Supplement Insurance (Medigap) policies offered prescription drug coverage before January 1, 2006. This isn't Medicare prescription drug coverage.

For more information, read "Your Guide to Medicare Prescription Drug Coverage" at Medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf.

Medicare Part D Drug Coverage

Medicare drug plans may be different from each other in terms of which prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must give at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Plans may offer more coverage and additional drugs, generally for a higher monthly premium.

Most plans will have a difference in offered benefits (costs that will vary,) including tiers, copayments, and/or deductibles. Enhanced plans may offer additional benefits, like coverage in the coverage gap or coverage for drugs that Medicare Part D doesn't traditionally cover.

Plan benefits and costs may change each year, so it's important to look at and compare your plan options annually.

Medicare Part D 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 (if applicable), copayments, and/or coinsurance.

Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once.

After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans. If you want to stop premium deductions and get billed directly, contact your drug plan.

When you're in the coverage gap, you pay a certain percentage for covered brand-name drugs, and a certain percentage for covered generic drugs. In 2017, it's 40% of the plan's cost for brand-name drugs and 51% of the plan's cost for generic drugs.

With every plan, once you've paid a certain threshold of out-of-pocket costs for drugs, (including payments from other sources, like the discount paid for by the drug company in the coverage gap) you leave the coverage gap and pay a small copayment for each drug for the rest of the year. For current coverage gap and out of pocket thresholds, visit Medicare.gov/partd/costs/part-d-costs.html.

Costs vary by plan, whether or not you have a late enrollment penalty, and whether or not you get Extra Help.

Part D Standard Benefit

Ms. Smith joins a Medicare Prescription Drug Plan. Her coverage begins on January 1. She doesn't get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She 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 $400 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 $3,700.	Once Ms. Smith and her plan have spent $3,700 for covered drugs, she's in the coverage gap. In 2017, she gets a 50% discount from the drug manufacturer on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2017, she gets an additional 10% coverage from her plan on covered brand-name drugs and 49% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent $4,950 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.

NOTE: If you get Extra Help, you won't have some of these costs.

You can visit the Medicare Plan Finder at Medicare.gov/find-a-plan to compare the cost of plans in your area. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP) at shiptacenter.org/.

Part D Eligibility Requirements

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

- The individual is enrolled in Medicare Part A and/or Part B
- The individual permanently resides in the service area of a PDP
- The individual is a U.S. citizen or lawfully present in the United States

An individual who is living abroad or is incarcerated is not eligible for Part D as he or she can't meet the requirement of permanently residing in the service area of a Part D plan.

Medicare drug coverage isn't automatic. Most people must join a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, you need to 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.

Part D Initial Enrollment Period (IEP)

If You Join	Coverage Begins
During the 3 months before you turn 65	Date eligible for Medicare
During the month you turn 65	First day of the following month
During the 3 months after you turn 65	First day of the month after month you apply

Some groups of people who become eligible for Extra Help will be enrolled in a Medicare drug plan unless they join a plan on their own.

NOTE: If you get Social Security or Railroad Retirement benefits when you turn 65, you'll be enrolled automatically in Medicare Part A and Part B. However, you'll still need to choose and enroll in a Part D plan during your IEP if you'd like to have Medicare drug coverage. If you enroll later, you may pay a penalty.

When You Can Join or Switch Plans

Medicare's annual Open Enrollment for Medicare Advantage and Medicare Prescription Drug Plan is October 15–December 7 with changes going into effect on January 1.

January 1–February 14

- If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch, you have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Coverage starts the first day of the month after the plan gets the enrollment form.

April 1–June 30 (limited)

- If you don't have Medicare Part A coverage, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan from April 1–June 30. Your coverage begins July 1.

Special Enrollment Period (SEP)

You can change your Medicare prescription drug coverage when certain events happen in your life. These chances to make changes are called Special Enrollment Periods (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 properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable
- If 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 Medicare drug plan at any time
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating
- Other exceptional circumstances, like if you no longer qualify for Extra Help

NOTE: It's important to remember that the SEPs for Part B and Part D have different time frames for when you can sign up for coverage. You may be eligible for a Medicare Part B SEP if you're over 65 and you (or your spouse) are still working and have health insurance through current active employment. 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 coverage ends. SEP options will display for you if you enroll through the Medicare Plan Finder at Medicare.gov. By checking any of the listed SEPs, you're certifying that, to the best of your knowledge, you're eligible for an enrollment period. If at a later time it's determined that this information was incorrect, you may be disenrolled from the plan.

5-Star Special Enrollment Period (SEP)

Plans are assigned their star rating once per year, in October. However, the plan won't actually get this rating until the following January 1. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan. Look for the Overall Plan Rating to identify 5-star plans that you can change to during this Special Enrollment Period (SEP). The "Medicare & You" handbook doesn't have the full, updated ratings for this SEP.

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-star rating is considered excellent.

At any time during the year, you can use the 5-star SEP to enroll in a 5-star Medicare Advantage (MA)–only plan, a 5-star MA plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Medicare 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 prescription drug plans. 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. 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 gets your enrollment request.

NOTE: You may lose prescription drug coverage if you use this SEP to move from a plan that has drug coverage to a plan that has no drug coverage. You'll have to wait until the next applicable enrollment period to get drug coverage and may have to pay a penalty.

Part D Late Enrollment Penalty

If you choose not to join a Medicare drug plan at your first opportunity, you may have a monthly penalty added to your monthly premium if you enroll later. If you have creditable coverage (coverage is expected to pay on average as much as the standard Medicare prescription drug 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.

The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium ($35.63 in 2017) times the number of full, uncovered 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 the plan in which you're enrolled. 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.

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. You may have to pay this penalty for as long as you have a Medicare drug plan. If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to provide proof that supports your case.

Income-Related Monthly Adjustment Amount (IRMAA)

Your Yearly Income in 2016 Filing an Individual Tax Return	Your Yearly Income in 2016 Filing a Joint Tax Return	In 2017 You Pay Monthly
$85,000 or less	$170,000 or less	Your Plan Premium (YPP)
Above $85,000 Up to $107,000	Above $170,000 Up to $214,000	YPP + $13.30*
Above $107,000 Up to $160,000	Above $214,000 Up to $320,000	YPP + $34.20*
Above $160,000 Up to $214,000	Above $320,000 Up to $428,000	YPP + $55.20*
Above $214,000	Above $428,000	YPP + $76.20*

***IRMAA is adjusted each year, as it's calculated from the annual beneficiary base premium.**

Part D Covered Drugs

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 U.S. 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 (for example, antibodies, proteins, and cells). Medicare also covers medical supplies associated with the injection of insulin, like syringes, needles, alcohol swabs, and gauze.

To make sure people with different medical conditions can get the prescriptions they need, drug lists (formulary) for each plan must include a range of drugs in each prescribed category. All Medicare drug plans generally must cover at least 2 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.

Even if a plan's prescription drug list doesn't include your specific drug, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who's 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.

Required Coverage

Medicare drug plans must cover all drugs in these 6 protected categories to treat certain conditions:

1) Cancer medications
2) HIV/AIDS treatments
3) Antidepressants
4) Antipsychotic medications
5) Anticonvulsive treatments for epilepsy and other conditions
6) Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots). You or your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need. For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

NEW!

Requirement for Prescribers

Any doctor or other eligible professional who prescribes Part D drugs must either enroll in the Medicare Program or opt out to prescribe drugs to their patients with Part D plans. Medicare Part D may no longer cover drugs that are prescribed by doctors or other eligible professionals who aren't validly enrolled, or opted out of Medicare. The enforcement of the prescriber enrolment requirement began on February 1,2017. All prescribers should've enrolled in the Medicare Program before February 1, 2017, to allow for the processing of applications and to ensure enrollees get their
prescriptions.

This includes eligible professionals (such as dentists, doctors, residents, psychiatrists, nurse practitioners, and doctor assistants). Dentists, including oral surgeons, won't be able to participate in a Medicare Advantage Plan if they choose to opt-out of Medicare. Upon submission of an opt-out affidavit, a provider has 90 days to change their opt-out status. After 90 days, a provider isn't able to terminate their opt-out designation and will remain in an opt-out status for 2 years.
For more information visit cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html.

NOTE: Pharmacists by statute aren't permitted to enroll in Medicare. Therefore, they're excluded from having to enroll in Medicare or opt-out for Part D plans to cover the prescriptions they write. Prescribing pharmacists should note that they still must have an active and valid individual National Provider Identifier (NPI), and all other Part D coverage requirements still must be met. In addition, CMS strongly recommends that pharmacists make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist.

Drugs Excluded by Law Under Part D

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

- Drugs for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose like morbid obesity).
- 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 U.S. Food and Drug Administration 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 (for example, 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.

Visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf (42 CFR 423.100) for more information on excluded drugs.

How Plans Manage Access to Drugs

Medicare drug plans manage access to covered drugs in several ways. These are known as "Coverage Rules." These include prior authorization, step therapy, and quantity limits.

Prior Authorization	▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered
Step Therapy	▪ Must first try similar, less expensive drug ▪ Doctor may request an exception if • Similar, less expensive drug didn't work, or • Step therapy drug is medically necessary
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Doctor may request an exception if additional amount is medically necessary

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, your doctor or other prescriber must first show the plan you have a medically necessary need for that particular drug. Plans also do this to be sure you're using these drugs correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Step therapy is a type of coverage rule. In most cases, you must first try a certain less expensive drug on the plan's drug list 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, some plans may require you first try a generic drug (if available), and then a less expensive brand-name drug on their drug list before you can get a similar, more expensive brand-name drug covered.

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

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.
For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf (see Section 30.2.2).

Formulary

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

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
4 or Specialty	Highest copayment or coinsurance	Unique, very high cost

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

- **Tier 1–Generic drugs** (the least expensive)—Tier 1 drugs are generic drugs and are the same as their brand-name counterparts in safety, strength, quality, the way they work, how they're taken, and the way they should be used. They use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. They're less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration (FDA). Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.

- **Tier 2–Preferred brand-name drugs**—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drug**—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4–(or Specialty Tier)**—These drugs are unique and have a high cost.

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

What'is a Medicare Advantage Plan?

Medicare Advantage (MA) Plans are health plan options that are approved by Medicare and run by private companies.

They're part of the Medicare Program and are sometimes called Part C.

MA Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays these private plans for their members' expected health care.

MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn't cover, like vision or dental services or allowances. The plan may have special rules that its members need to follow.

How Medicare Advantage (MA) Plans Work

In Medicare Advantage (MA) Plans, you get all Medicare-covered Part A (Hospital Insurance) and Part B (Medical Insurance) services through that plan. Some MA Plans provide additional benefits.

Many plans also include Medicare prescription drug coverage. This is Medicare Part D coverage.

In some plans, like Medicare Health Maintenance Organizations (HMOs), you may only be able to see certain doctors or go to certain hospitals. You save the most money out of pocket when you get services through the plan's network.

Benefits and cost-sharing in an MA Plan may differ from Original Medicare.

It's important to note that when you join a Medicare Advantage (MA) Plan or other Medicare health plan you're still in the Medicare Program. Medicare pays these private health plans for your care every month whether you use services or not.

You still have Medicare rights and protections.

You'll have the opportunity to join another MA Plan or return to Original Medicare if the plan decides to stop participating in Medicare.

Medicare Advantage Costs

If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2017 is $109 for most people; $134 for those not "held harmless."

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

When you join an MA Plan there are other costs you may have to pay, such as
- An additional monthly premium to the plan
- Deductibles, coinsurance, and copayments
    - These costs may
        - Be different from Original Medicare
        - Vary from plan to plan
        - Be higher if you go out of network

Who Can Join a Medicare Advantage Plan?

- Medicare Advantage (MA) Plans are available to most people with Medicare. To be eligible to join an MA Plan, you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area. You must be a United States (U.S.) citizen or lawfully present in the U.S., and you can't be incarcerated.

- To join an MA Plan, you must also agree to
    - Provide the necessary information to the plan, such as your Medicare number, address, date of birth, and other important information
    - Follow the plan's rules
    - Belong to only belong to one MA Plan at a time

To find out which MA Plans are available in your area, visit [Medicare.gov/find-a-plan/(X(1)S(2luz5a2efeq4xoilzh144gnd))/questions/home.aspx]() and click "Find Health and Drug Plans," or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

When You Can Join or Switch Medicare Advantage Plans

Initial Enrollment Period (Technically the Initial Coverage Enrollment Period)	▪ 7-month period begins 3 months before the month you turn 65 ▪ Includes the month you turn 65 ▪ Ends 3 months after the month you turn 65 **Important:** If you delay Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted.

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

Important: If you delay Medicare Part B enrollment (for example, due to active employer group coverage), your time to enroll in an MA Plan may be more restricted. Your IEP begins 3 months before your eligibility to both Medicare Part A and Part B. It ends on the day before your eligibility to Part A and Part B begins, or the last day of your Part B Initial Enrollment Period, whichever is later. For more information, see the Medicare Managed Care Manual, Chapter 2, at CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2017_MA_Enrollment_and_Disenrollment_Guidance_8-25-2016.pdf.

Fall Open Enrollment	▪ October 15—December 7 ▪ Coverage begins January 1
Medicare due to a Disability	▪ 7-month period begins 3 months before the 25th month of disability. ▪ Ends 3 months after the 25th month of disability.

Special Enrollment Periods (SEPs)	▪ Move out of your plan's service area ▪ You have Medicaid ▪ Plan leaves Medicare Program or reduces its service area ▪ Leaving or losing employer or union coverage ▪ You enter, live at, or leave a long-term care facility ▪ You have a continuous SEP if you qualify for Extra Help ▪ Losing your Extra Help status ▪ You join or switch to a plan that has a 5-star rating ▪ Retroactive notice of Medicare entitlement ▪ Other exceptional circumstances

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in a Medicare Advantage Plan, or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4 at CMS.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf.

5-Star Special Enrollment Period (SEP)	▪ Can enroll in 5-star MA Plan, Prescription Drug Plan (PDP), Medicare Advantage Plan with prescription drug coverage (MA-PD), or Cost Plan ▪ Enroll once yearly from December 8–November 30 ▪ New plan starts first day of month after enrolled ▪ Star ratings given once per year • Ratings assigned in October and effective January 1 • Use Medicare Plan Finder to see star ratings ❑ Look at Overall Plan Rating to find eligible plans

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall star ratings to plans. Plans get rated from 1 to 5 stars. A 5-star rating is considered excellent.

You can use the 5-star Special Enrollment Period (SEP) to enroll in a 5-star Medicare Advantage (MA)-only Plan, a 5-star MA Plan with prescription drug coverage (MA-PD), a 5-star Medicare Prescription Drug Plan (PDP), or a 5-star Medicare 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.

The Centers for Medicare & Medicaid Services (CMS) also created a coordinating SEP for prescription drug plans. This SEP lets people who enroll in certain types of 5-star plans without drug coverage choose a prescription drug plan, if that combination is allowed under CMS rules.

You may use the 5-star SEP to change plans one time each year between December 8–November 30. 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 gets your enrollment request.

Plans get their star ratings in October, effective January 1. To find star rating information, visit the Medicare Plan Finder at Medicare.gov/find-a-plan. 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.

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

When You Can Leave a Medicare Advantage (MA) Plan

January 1 – February 14	▪ You can leave an MA Plan ▪ Switch to Original Medicare • Coverage begins first day of month after switch • May join Part D Plan ❑ Drug coverage begins first day of month after plan gets enrollment ▪ May not join another MA Plan during this period ▪ May be able to buy a Medicare Supplement Insurance (Medigap) policy

Types of Medicare Advantage Plans

Medicare Advantage Plans include

- Health Maintenance Organization (HMO)
- HMO Point-of-Service
- Preferred Provider Organization
- Special Needs Plan
- Private Fee-for-Service
- Medicare Medical Savings Account

Other Types of Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage (MA) Plans, but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Medicare prescription drug coverage (Part D). These plans have some of the same rules as MA Plans. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details. Examples include Medicare Cost Plans, Innovation Projects and Pilot Programs, and Medicare Program of All-inclusive Care for the Elderly (PACE) plans.

NOTE: Additional details are provided in Module 11, "Medicare Advantage Plans and Other Medicare Health Plans" at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1241850.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

Compare Plans on Medicare Plan Finder

Visit Medicare.gov/find-a-plan/ and use the Medicare Plan Finder to:

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more

You should compare Medicare drug plans based on what's most important to your situation and your drug needs. You may want to ask yourself the following questions:

- Which plan(s) covers the prescriptions I take?
- Which plan(s) gives me the best overall price on all of my prescriptions?
- What's the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Which plan(s) allows me to use the pharmacy I want or get prescriptions through the mail?
- Which plan(s) gives me coverage in multiple states, if I need it?
- What star ratings did the plan(s) get?
- **Can my coverage start when I want it to?**
- Is it likely that I'll need protection against unexpected drug costs in the future?

For more information on Plan Finder, visit cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1239988.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending.

Practice website to be used with approved training scenarios: training.medicare.gov/find-aplan/questions/home.aspx.

Lesson 3: Rights and the Appeals Process

Medicare Guaranteed Rights

"Medicare Rights" explains that no matter how you get your Medicare, you have certain guaranteed rights and protections. We'll provide information on additional rights that are specific to how you choose to get your Medicare coverage.

- Original Medicare
- Medicare Advantage and other Medicare health plans
- Medicare Prescription Drug Coverage

Your Medicare rights and protections are designed to protect

- You when you get health care
- You against unethical practices
- Your ability to get the medically necessary health care services that the law says you can get
- Your privacy

Your Medicare Rights

If you have Medicare, you have the right to be

- Treated with dignity and respect at all times
- Protected from discrimination
  - Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your
    - Race, color, or national origin
    - Disability
    - Age
    - Religion
    - Sex

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who get federal financial assistance.

If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019. TTY: 1-800-537-7697. For more information, visit HHS.gov/ocr.

"Notice of Privacy Practices for Original Medicare"

Medicare is required to protect your personal medical information. The "Notice of Privacy Practices for Original Medicare" describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you're enrolled in a Medicare Advantage Plan or other Medicare health plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

The "Notice of Privacy Practices" is published annually in the "Medicare & You" handbook at Medicare.gov/medicare-and-you. To learn more about the "Notice of Privacy Practices for Original Medicare', visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.

For more information, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Who's the Medicare Beneficiary Ombudsman?

An ombudsman is a person who receives complaints and helps resolve them. At CMS, the Medicare Beneficiary Ombudsman (MBO) reviews concerns raised by Medicare beneficiaries and represents the voice of the Medicare beneficiary to CMS.

The MBO helps make sure information is available about:

- Medicare coverage, including information about how to get Medicare covered benefits
- How to file a complaint with Medicare, or a Medicare plan, to get concerns resolved
- Your Medicare rights and protections, including information on how to file an appeal

The MBO receives concerns raised by people with Medicare from a variety of sources, including 1-800-MEDICARE and the State Health Insurance Assistance Programs (SHIP).

The MBO publicly reports their yearly activities to the Secretary of Health & Human Services and Congress, which includes recommendations for improvements to the Medicare program.

Visit Medicare.gov for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

Medicare Rights – Claims and Appeals

If you have Medicare, you have the right to the following:

- Have a claim for payment filed with Medicare and get a decision about health care payment, coverage of services, or prescription drugs, even when your doctor says that Medicare won't pay for a certain item or service.

- When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.

- Appeal if you disagree with a decision about your health care payment, coverage of services, or prescription drug coverage.
    - For more information about appeals, visit Medicare.gov/appeals.
    - For help with filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP phone numbers, visit shiptacenter.org/.
    - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

Medicare Grievance Rights

If you have Medicare, you have the right to the following:

- File complaints (also called grievances) about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
- If you're concerned about the quality of care you're getting
    - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your region to file a complaint. Visit Medicare.gov/contacts to get your BFCC-QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.
    - In a Medicare Advantage or other Medicare health plan, call the BFCC-QIO, your plan, or both.
    - If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Medigap Rights in Original Medicare

A Medicare Supplement Insurance(Medigap) Policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, such as coinsurance amounts.

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

- In some situations, you have the right to buy a Medigap policy. Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a standardized Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.

- You have the right to buy a Medigap policy during your Medigap Open Enrollment Period, a 6-month period that automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.
- When you have guaranteed issue rights, the Medigap policy
  - Can't deny you Medigap coverage or place conditions on your policy
  - Must cover you for pre-existing conditions
  - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies.

NOTE: Module 3, "Medigap (Medicare Supplement Insurance) Policies," describes these situations at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

Coverage and Appeal Rights in Medicare Health Plans

If you're in a Medicare health plan, you have the right to

- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about the plan's coverage rules.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.
  - The appeals process consists of 5 levels.
  - If coverage is denied at any appeal level, you'll get a letter explaining the decision and instructions on how to proceed to the next appeal level.
  - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity.
- File a grievance about other concerns or problems with your plan, check your plan's membership materials, or call your plan to find out how to file a grievance.

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details at Medicare.gov/pubs/pdf/11534.pdf.

Requesting Part D Appeals

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. Most appeals must be requested within 60 days of the coverage determination or denial of an exception. However, this timeframe may be extended for good cause (a circumstance that kept the party from making the request on time or whether any actions by the plan may have misled the party). For more information

on good cause, see Chapter 18 of the Prescription Drug Benefit Manual "Part D Enrollee Grievances, Coverage Determinations, and Appeals," Section 70.3—"Good Cause Extension" at CMS.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/index.html.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited (fast) redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You or your appointed representative (see Appendix F) may ask for any level of appeal. Your doctor or other prescriber can only ask for redetermination or Independent Review Entity reconsideration (level 1 or 2 appeal) on your behalf without being your appointed representative. The Appointment of Representative form is available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/Cms-Forms-Items/CMS012207.html.

Lesson 4: Programs for People With Limited Income and Resources

What Is Medicaid and the Children's Health Insurance Program (CHIP)?

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 (Medicaid) Office to see if you qualify.

The Children's Insurance Program (CHIP) provides federal matching funds to states to provide health coverage to children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. CHIP covers uninsured children up to 19, and it may also cover pregnant women when family income's too high for Medicaid.

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

- 1-800-MEDICARE (TTY: 1-877-486-2048)
- Your State Health Insurance Assistance Program (SHIP)
- Or visit your State Medical Assistance (Medicaid) Office

NOTE: Module 12, “Medicaid,” describes this topic in more detail at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

To also see “Federal Policy Guidance,” visit Medicaid.gov/federal-policy-guidance/federal-policyguidance.html.

Medicare Savings Programs

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.

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

NOTE: Federal law bars Medicare and MA providers from balance billing a QMB beneficiary under any circumstances—Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Medicare beneficiaries who are interested in qualifying for financial "extra help" with the Medicare Part D Prescription Drug plans should visit SocialSecurity.gov/i1020. 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 (SPAPs).

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 visit shiptacenter.org.

NOTE: For annual updates, visit Medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html. For more information, visit “Getting Help with your Medicare Costs” at Medicare.gov/Pubs/pdf/10126.pdf.

What is Extra Help?

Resource limits are announced in the fall. Then the Federal Poverty Level (FPL) guidelines are updated annually late in the following January (aspe.hhs.gov/poverty-guidlelines) and determine the income level requirements for people applying for the Medicare Part D Low-Income Subsidy (LIS) program, also known as the "Extra Help" program. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs.

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 and can switch plans at any time, with the new plan going into effect the first day of the next month.

It's easy and free to apply for "Extra Help." You or a family member, trusted counselor, or caregiver can apply online at socialsecurity.gov/i1020 or call Social Security at 1-800-772-1213. TTY: 1-800-325-0778.

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.

See Guide to Consumer Mailings (Social Security LIS and MSP Outreach Notice), which are issued in mid-May and late November CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/downloads/2015Mailings.pdf.

Qualifying for 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). Medicare will provide "Extra Help" that may cover 85% to 100% of prescription costs, and may also pay a part or all of your Medicare Part D premiums.

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 Medical Assistance (Medicaid) Office.

You may qualify for Extra Help in 2017, if your yearly income is below $17,820 for a single person (or $24,030 for a married couple living together or even more if you have dependent children or grandchildren living with you), AND if your assets are below $13,640 for a single person (or $27,250 if you're married). 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). You can apply for Extra Help by completing a paper application you can get by calling Social Security at 1-800-772-1213. TTY: 1-800-325-0778. You may also apply online at ssa.gov/i1020; you may also apply through your state Medicaid agency, or by working with a local organization, such as your State Health Insurance Assistance Programs (SHIP).

Steps to Take

Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses through Medicaid, CHIP, a Medicare Savings Program or Extra Help.

1) Review the income and resource (or asset) guidelines for your area.
2) If you think you may qualify, collect the personal documents the agency requires for the application process. You will need
    - Your Medicare card
    - Proof of identity
    - Proof of residence
    - Proof of any income, including pension checks, Social Security payments, etc.
    - Recent bank statements
    - Property deeds
    - Insurance policies
    - Financial statements for bonds or stocks
    - Proof of funeral or burial policies
3) You can get more information by contacting your State Medical Assistance (Medicaid) Office, your local State Health Insurance Assistance Program, or your local Area Agency on Aging.
4) Complete an application with your State Medical Assistance (Medicaid) Office.

Programs in U.S. Territories

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 at Medicare.gov/contacts/.

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

Lesson 5: Medicare and the Health Insurance Marketplace

Marketplace and People With Medicare

Medicare isn't a part of the Health Insurance Marketplace. Medicare Part A provides minimum essential coverage. If you have Medicare, you don't have to do anything related to the Marketplace. The Marketplace doesn't change your Medicare plan choices or your benefits. Medicare plans and Medicare Supplement Insurance (Medigap) Policies aren't available in the Marketplace. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Part B. The exception is coverage from your employer through the Small Business Health Options Program. If you receive your coverage this way

- The Small Business Health Options Program (SHOP) employer coverage may pay first
- You could delay Medicare enrollment without a penalty
    - This doesn't include COBRA coverage

Marketplace and Becoming Eligible for Medicare

If you have coverage through an individual Health Insurance Marketplace plan (not through an employer), you may want to terminate your Marketplace coverage and enroll in Medicare during your Initial Enrollment Period to avoid the risk of a delay in future Medicare coverage and the possibility of a Medicare late enrollment penalty. Once you're considered eligible for Part A, you won't qualify for help paying your Marketplace plan premiums or other medical costs. If you continue to get help paying your Marketplace plan premium after you have Medicare, you might have to pay back the help you got when you file your taxes. Visit HealthCare.gov to connect to the Marketplace in your state and learn more. You can also find out how to terminate your Marketplace plan before your Medicare enrollment begins.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period (IEP) to sign up. For most people, their 7-month Medicare IEP starts 3 months before their 65th birthday and ends 3 months after their 65th birthday. If you enroll in Medicare after your IEP, you may have to pay a late enrollment penalty for as long as you have Medicare.

If you have individual Marketplace coverage and only enroll in Part A during your IEP, you won't be able to enroll in Part B later using the Special Enrollment Period.

NOTE: You may have Medicare and Marketplace coverage concurrently, only if you had your Marketplace coverage before you had Medicare. It's against the law for someone who knows you have Medicare to sell you a Marketplace plan. There is no coordination of benefits between a Qualified Health Plan(QHP) and Medicare. You need to be aware of this if you decide to remain in a QHP after enrolling into Part A. It isn't a secondary insurance. Also, drug coverage in QHP may not be creditable and a penalty may result if you sign up for Part D later.

If You Have a Marketplace Plan First and Then Get Medicare Coverage

You can get a Marketplace plan to cover you before your Medicare begins. If you choose to drop your Marketplace plan, you must contact the plan at least 14 days before you want that coverage to end. However, it's important that you time the end of your Marketplace plan so that you don't have a gap in coverage.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period to sign up. In most cases it's to your advantage to sign up when you're first eligible because once you're getting Medicare, you won't be able to get lower costs for a Marketplace plan based on your income like premium tax credits and reduced cost-sharing (except if you only have Part B).

If you have limited income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/copayments.

Choosing Marketplace Instead of Medicare

It's against the law for someone who knows you have Medicare to sell you a Marketplace plan policy. You can choose Marketplace coverage instead of Medicare if you

- Would have to pay a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan instead
- Only have Part B and would have to pay a premium for Part A, you can drop Part B and get a Marketplace plan instead
- Have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage
- You're not yet collecting Social Security retirement or disability benefits and not yet eligible for Medicare based on age (or you're in the waiting period)
- Medicare enrollment will be automatic once eligible and getting a Social Security Cash benefit.

Before choosing a Marketplace plan over Medicare, there are 2 important points to consider:

1) If you enroll in Medicare after your Initial Enrollment Period (IEP) ends, you may have to pay a late enrollment penalty (LEP) for as long as you have Medicare.
2) Generally you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1 to March 31). Your coverage won't begin until July of that year.

If you don't have or dropped Medicare Part A because you have to pay a premium, and instead enroll in a Marketplace plan, you'd be eligible for the premium tax credit and cost-sharing reductions, assuming that you meet the eligibility requirements for those programs.

REMEMBER: If you choose to enroll in Medicare later and keep your Qualified Health Plan (QHP) coverage, generally there's no coordination of benefits between a Marketplace plan and Medicare. You need to be aware of this, if you decide to remain in a QHP after enrolling into Medicare. Marketplace plans aren't secondary insurance. In fact, the QHP isn't required to pay any costs toward your coverage if you have Medicare.

Medicare for People With Disabilities and the Marketplace

If you're entitled to Social Security Disability Insurance (SSDI), you may qualify for Medicare. However, there is a 24-month waiting period before Medicare coverage can start. During this waiting period, you can apply for coverage in the Marketplace. You can find out if you'll qualify for Medicaid or for premium tax credits that lower your monthly Marketplace plan premium, and cost-sharing reductions that lower your out-of-pocket costs.

If you apply for lower costs in the Marketplace, you'll need to estimate your income for 2017. If you're getting Social Security disability benefits and want to find out if you qualify for lower costs on Marketplace coverage, you'll need to provide information about your Social Security payments, including disability payments.

Your Medicare coverage is effective on the 25th month of receiving SSDI. Your Medicare card will be mailed to you about 3 months before your twenty fifth month of disability benefits. If you don't want Part B, follow the instructions that are included with the card. However, once you're eligible for Medicare, you won't be able to get lower costs for a Marketplace plan based on your income.

Once your Part A coverage starts, any premium tax credits and reduced cost-sharing you may have qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

Also, remember, the QHP isn't required to pay any costs towards your coverage once you have Medicare.

Marketplace/ Medicare Enrollment Considerations

There are a few situations where you can choose a Marketplace private health plan instead of Medicare.

1) If you're paying a premium for Part A. In this case you can drop your Part A and Part B coverage and get a Marketplace plan instead. In the rare instance that you only have Part B, you also could drop it and get coverage in the Marketplace. If you're eligible for Medicare but haven't enrolled in it, this could be because you'd have to pay a premium; you have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease (ESRD), but haven't applied for Medicare coverage; or you're not collecting Social Security retirement or disability benefits before you're eligible for Medicare.

2) If you’re getting Social Security retirement or disability benefits before you’re eligible for Medicare, you’ll automatically be enrolled in Medicare once you’re eligible. Before choosing a Marketplace plan over Medicare, there are two important points to consider:
   - If you enroll in Medicare after your Initial Enrollment Period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could’ve had Part A, but didn't sign up (Note: If you’re already receiving Social Security benefits prior to becoming eligible then you’ll be automatically enrolled in Part A; no penalty would be applicable here). If you don’t enroll in Part B when first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. You may owe a Part D late enrollment penalty if, at any time after your Initial Enrollment Period (IEP) is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Marketplace plans aren’t required to provide creditable drug coverage. You may have to pay this penalty as long as you have Part D coverage.
   - Generally, if you miss your IEP, you can enroll in Medicare only during the Medicare General Enrollment Period (from January 1 to March 31 each year). Your coverage won’t start until July. This may cause a gap in your coverage.

Employer coverage offered through the Small Business Health Options Program (SHOP) is treated like any other employer coverage. Medicare Secondary Payer rules apply. “Medicare & the Health Insurance Marketplace,” For more information, view the publication CMS Product No. 11694 at Medicare.gov/Pubs/pdf/11694.pdf.

Introduction to Medicare Resources Guide

Resources

Centers for Medicare & Medicaid Services (CMS)

- 1-800-MEDICARE (1-800-633-4227).
  TTY: 1-877-486-2048.
- Medicare.gov
- CMS.gov
- Medicaid.gov/

Social Security

- 1-800-772-1213. TTY: 1-800-325-0778
- SocialSecurity.gov/

Railroad Retirement Board

- 1-877-772-5772. TTY: 1-312-751-4700
- RRB.gov/

Affordable Care Act

- HealthCare.gov
- HHS.gov/healthcare/about-the-aca/index.html

Medicare Plan Finder

- Medicare.gov/find-a-plan

State Health Insurance Assistance Programs and State Insurance Departments

SHIP

- shiptacenter.org/

U.S. Department of Health and Human Services, Office for Civil Rights

- HHS.gov
- HHS.gov/ocr/office/index.html
- 1-800-368-1019. TTY: 1-800-537-7697

Additional Resources

- Benefits.gov
- InsureKidsNow.gov

Introduction to Medicare Resources Guide (continued)

Medicare Products

1. **“Medicare & You Handbook”**
   CMS Product No. 10050
2. **“Your Medicare Benefits”**
   CMS Product No. 10116
3. **“Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare”**
   CMS Product No. 02110
4. **“Medicare & the Health Insurance Marketplace”**
   CMS Product No. 11694
5. **“Welcome to Medicare”**
   CMS Product No. 11095
6. **“Are You a Hospital Inpatient or Outpatient?”**
   CMS Product No. 11435
7. **“Medicare Coverage of Skilled Nursing Facility Care”**
   CMS Product No. 10153
8. **“Medicare and Home Health Care”**
   CMS Product No. 10969
9. **“Medicare Hospice Benefits”**
   CMS Product No. 02154
10. **“Who Pays First”**
    CMS Product No. 02179
11. **“Your Guide to Medicare Prescription Drug Coverage”**
    CMS Product No. 11109
12. **“Getting Help with your Medicare Costs”**
    CMS Product No. 10126
13. **“Medicare & the Health Insurance Marketplace”**
    CMS Product No. 11694 “

To access these products

- View and order single copies at Medicare.gov/publications
- Order multiple copies (partners only) at productordering.cms.hhs.gov.
  You must register your organization.

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Acronyms

- BPH Benign Prostatic Hyperplasia
- BFCC-QIO Beneficiary and Family Centered Care Quality Improvement Organization
- CHAMPVA Civilian Health and Medical Program of the Department of Veterans Affairs
- CHIP Children's Health Insurance Program
- CMS Centers for Medicare & Medicaid Services
- COBRA Consolidated Omnibus Budget Reconciliation Act
- DME Durable Medical Equipment
- EGHP Employer Group Health Plan
- ESRD End-Stage Renal Disease
- FDA Food and Drug Administration
- FICA Federal Insurance Contributions Act
- FPL Federal Poverty Level
- GEP General Enrollment Period
- 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
- NTP National Training Program

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Acronyms (continued)

- NPI National Provider Identifier
- OEP Open Enrollment Period
- 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
- QHP Qualified Health Plans
- RNHCI Religious Nonmedical Health Care Institution
- RRB Railroad Retirement Board
- SEP Special Enrollment Period
- SHIP State Health Insurance Assistance Program
- SHOP Small Business Health Options Program
- SLMB Specified Low-income Medicare Beneficiary
- SNF Skilled Nursing Facility
- SNP Special Needs Plan
- SPAP State Pharmaceutical Assistance Program
- SSA Social Security Administration
- SSDI Social Security Disability Insurance
- SSI Supplemental Security Income
- TFL TRICARE for Life
- TTY Teletypewriter

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