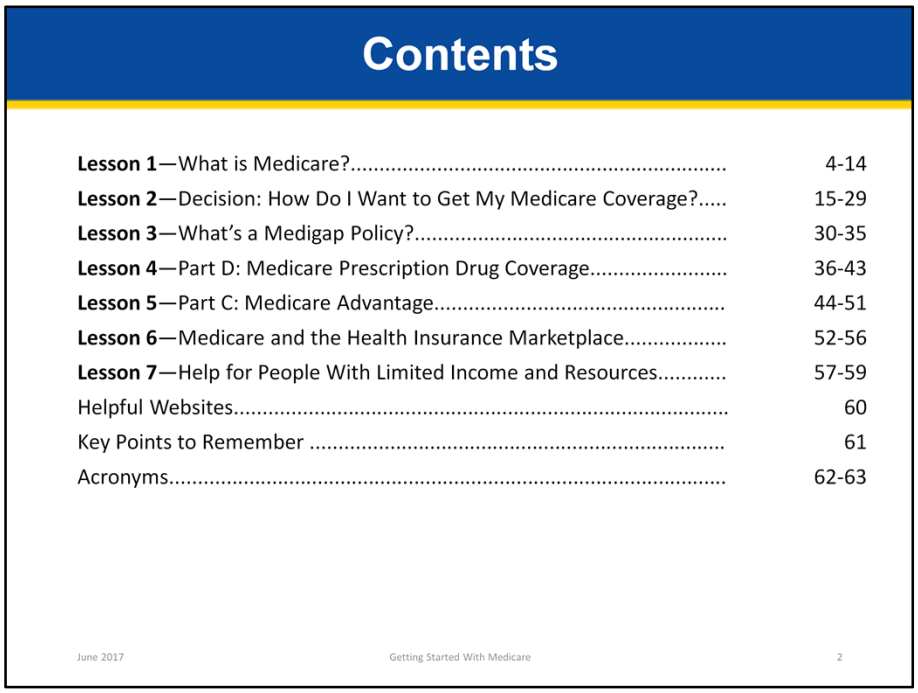
The lessons in this module, "Medicare—Getting Started," provide an overview of the Medicare Program basics including Part A (Hospital insurance), Part B (Medical Insurance), Medicare Supplement Insurance (Medigap) Policies, Part C (Medicare Advantage (MA) Plans), Part D (Prescription Drug Coverage), the Federally-facilitated Health Insurance Marketplace, Medicaid, and other programs to help people with limited income and resources, and related resources.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of June 2017. To check for an updated version, visit CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.

The CMS National Training Program provides this as an informational resource for our partners. It's not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.



The materials are designed for information givers/trainers that are familiar with the Medicare Program, and would like to have prepared information for their presentations for new partners who counsel people with Medicare.

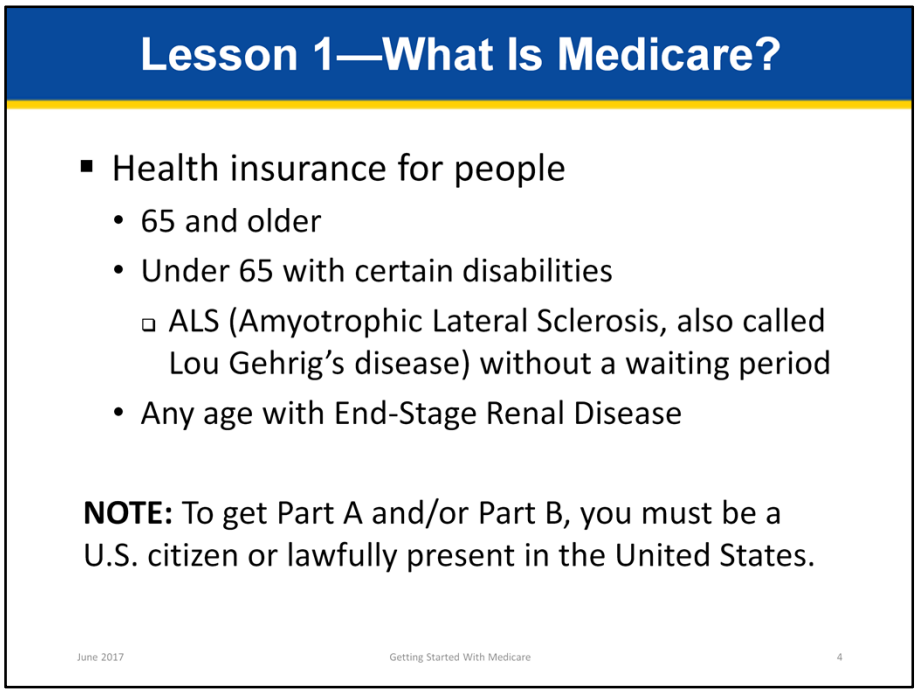
The module consists of 64 PowerPoint slides with corresponding speaker's notes, web links, and 9 check-your-knowledge questions. It can be presented in about 60 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

Additional materials available:

- Publications
  - "Welcome to Medicare"
  - "Understanding Medicare Part C & D Enrollment Periods"
- Job Aids
  - Medicare card
  - Web Resources

This session should help you

- Compare the parts of Medicare and coverage options
- Explain benefits and costs
- Discuss how Medigap policies and Medicare Advantage Plans are different
- Describe the Federally-facilitated Health Insurance Marketplace
- Recognize Medicaid and related resources



Medicare currently provides health insurance for 55 million U.S. citizens.

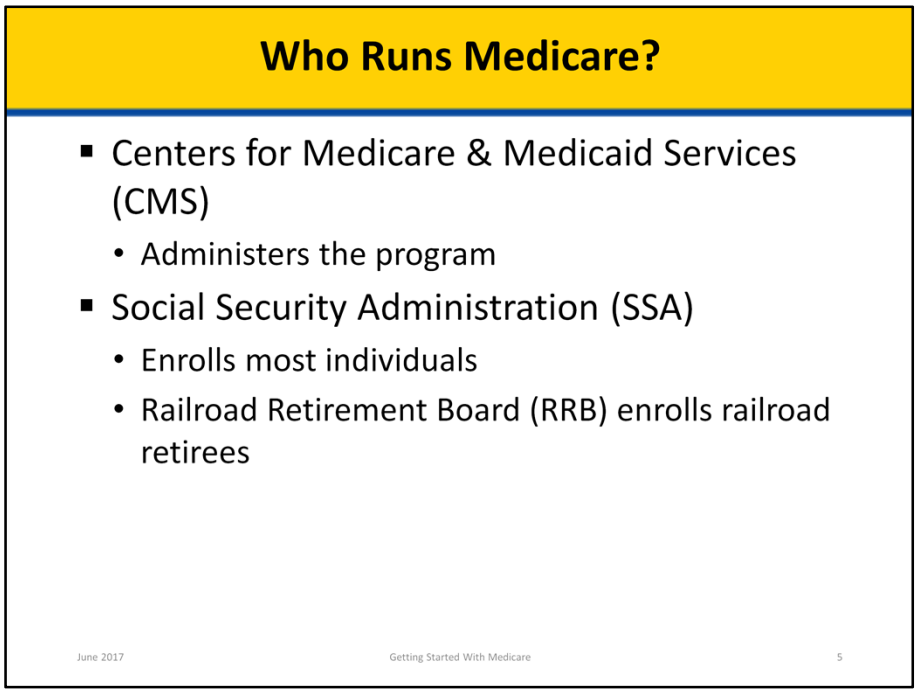
- Medicare is health insurance for generally 3 groups of people:
  - Those who are 65 and older
  - People under 65 with certain disabilities who have been entitled to Social Security Disability Insurance benefits for 24 months—includes ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), 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

A very small subset of people can get Medicare based on a federally-declared environmental health hazard who have an asbestos-related condition associated with that hazard. Currently it only applies to individuals affected by a hazard in Libby, Montana.

NOTE: To get Part A and/or Part B, you must be a U.S. citizen or lawfully present in the United States. If you live in Puerto Rico, you must actively enroll in Part B. Please refer to the section in this presentation entitled "When Enrolling Isn't Automatic" beginning on page 10 for further details about enrollment requirements.

Resources:

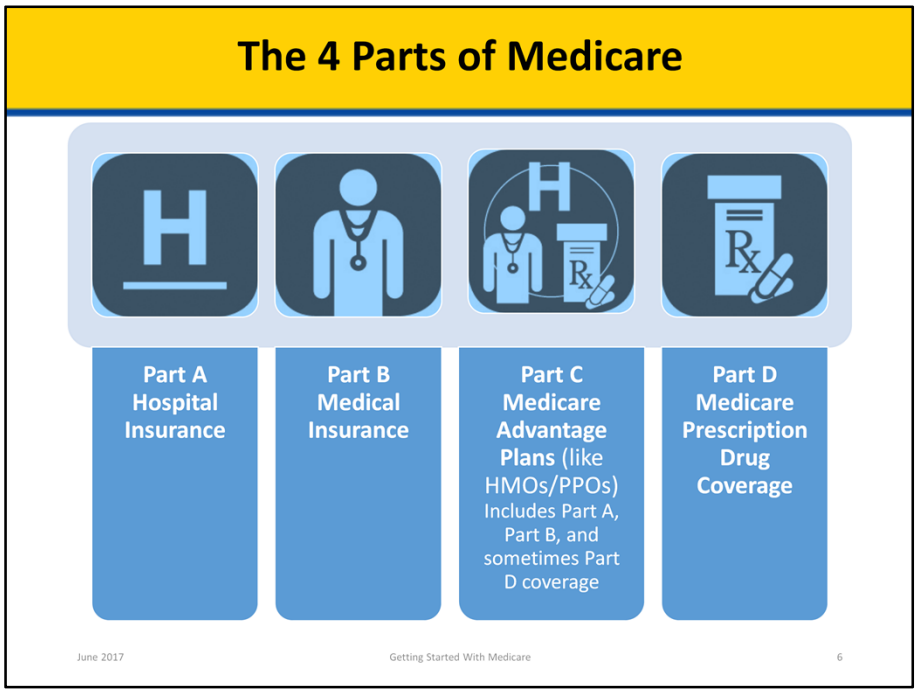
- Medicare & You handbook Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf
- CMS.gov/Medicare/Coverage/CoverageGenInfo/index.html



The Centers for Medicare & Medicaid Services (CMS) administers the Medicare Program. For more information, visit CMS.gov.

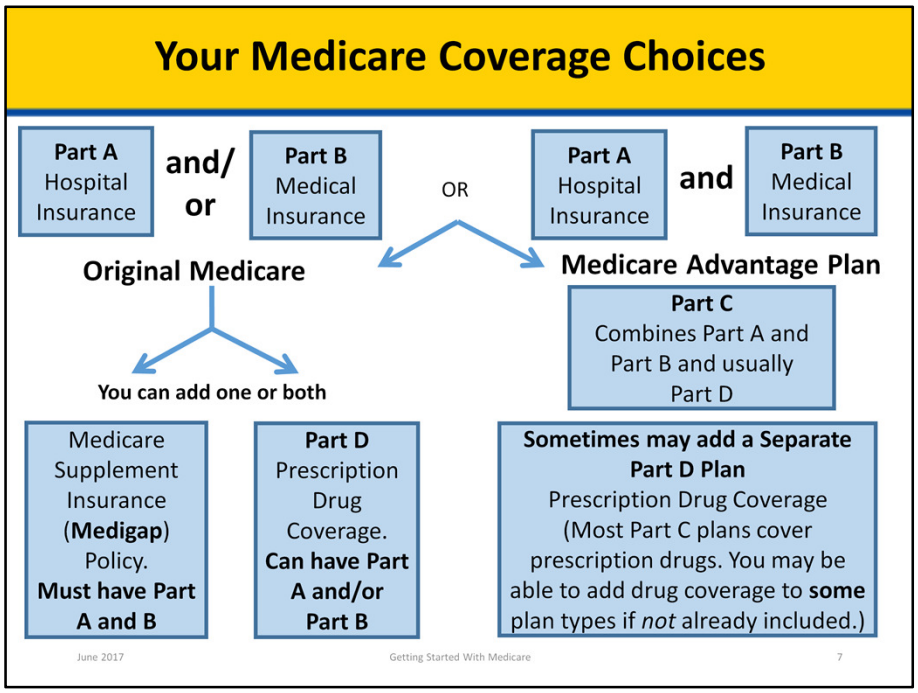
However, Social Security is responsible for enrolling most people in Medicare. For more information, visit socialsecurity.gov.

If you're a railroad retiree, the Railroad Retirement Board will handle your enrollment. For more information, visit RRB.gov.



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

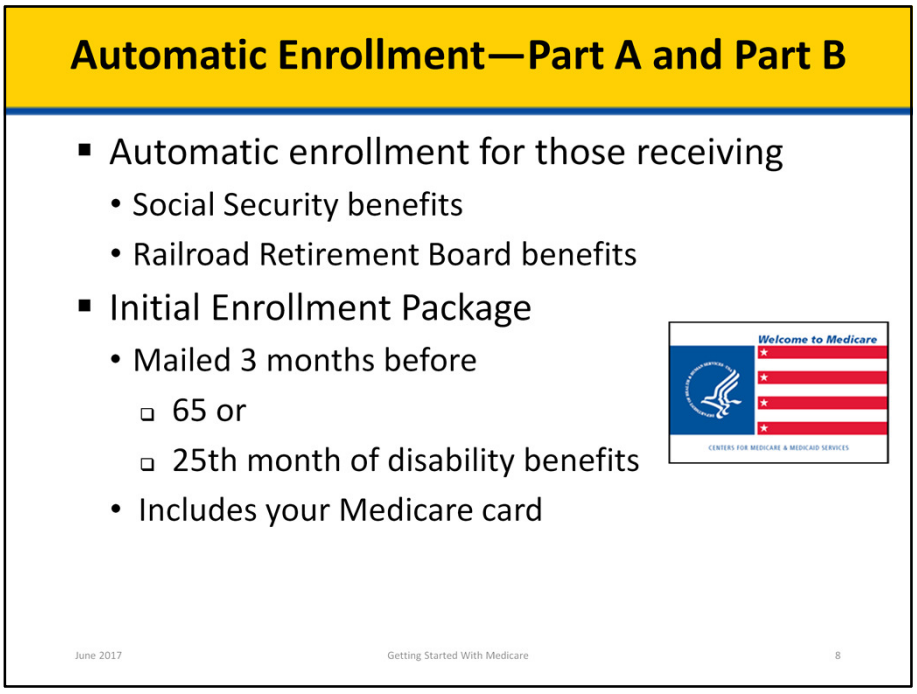
- **Part A (Hospital Insurance)** helps pay for inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.
- **Part B (Medical Insurance)** helps cover medically necessary services like doctor visits and outpatient care. Part B also covers many preventive services (including 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.



There are 2 main ways to get your Medicare coverage, Original Medicare, or Medicare Advantage (MA) Plans. You can decide which way to get your coverage.

- Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). You can choose to buy a Medigap Policy to help cover some costs not covered by Original Medicare. You can also choose to buy Medicare prescription drug coverage (Part D) from a Medicare Prescription Drug Plan (PDP).
- MA Plans (Part C), like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover Part A and Part B services and supplies. They also may include Medicare prescription drug coverage (MA-PD). You can add a Medicare Prescription Drug Plan to a Medicare Private Fee-for-Service Plan or Cost Plan if they don't provide Part D coverage, and you can add it to a Medicare Medical Savings Account (MSA) Plans. You can't add a Part D plan to a Medicare HMO or PPO plan without drug coverage.

  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.

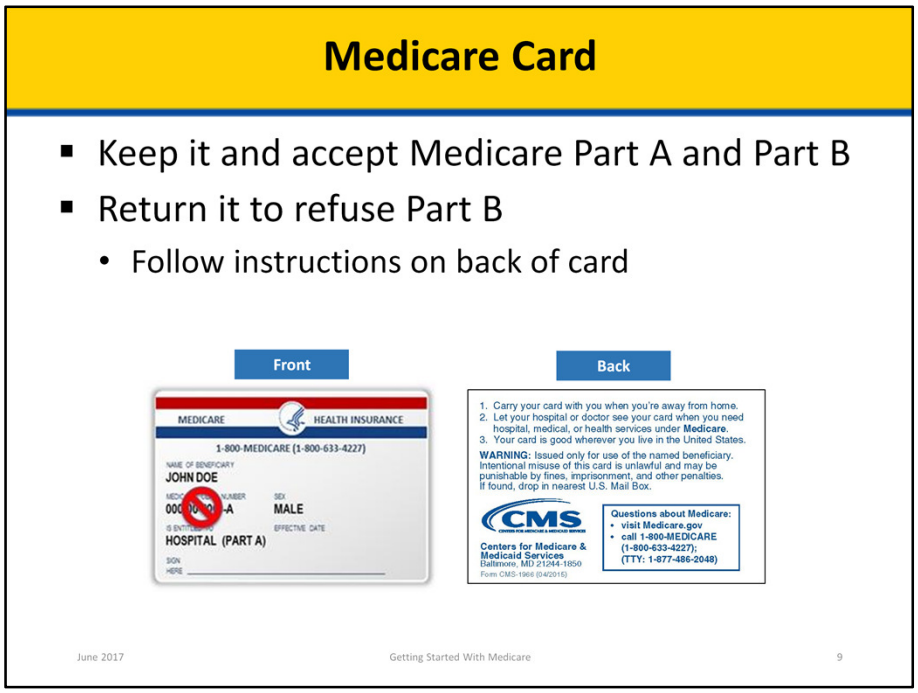


If you're already getting Social Security or Railroad Retirement Board (RRB) benefits (for example, getting early retirement at least 4 months before you turn 65), you'll be automatically enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment package, 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 RRB, you must sign up to get Medicare (see page 10).

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-Welcome-to-Medicare.pdf.



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 show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you're related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a B or 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 get railroad retirement benefits) if any information on the card is incorrect.

If you get your Medicare card in your Initial Enrollment Period package and don't want Part B, follow the directions and return the card. We'll talk more about the few reasons why you might want to delay taking Part B. If you choose a Medicare Advantage Plan, your plan may give you a card to use when you get health care services and supplies.

NOTE: Social Security has an online service that lets you get a replacement Medicare card. To create your account and learn more about "my Social Security" accounts, visit SSA.gov/myaccount.

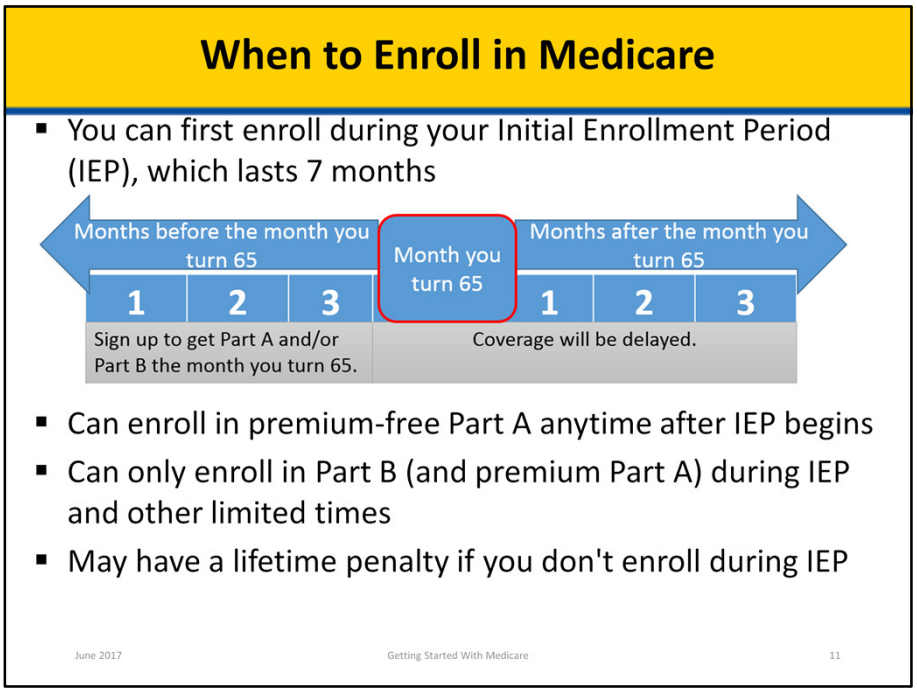
If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least 4 months before you turn 65 (for instance, because you're still working), you'll need to sign up for Part A and Part B (even if you're eligible to get Part A premium free). You should contact Social Security 3 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.

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

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.

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 get full Social Security retirement benefits is increasing, Medicare benefit eligibility due to age still begins at 65.



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.

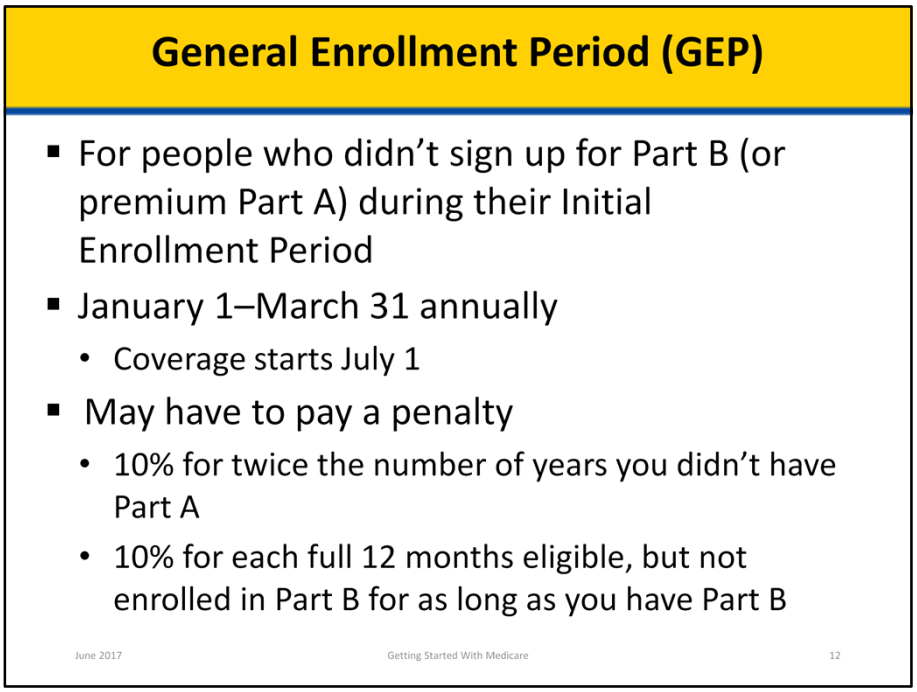
If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods. Only people who don’t qualify for free Part A must pay a premium for Part A coverage. You must pay a monthly premium for both Part B and premium Part A coverage.

If you enroll in free Part A later, your Part A coverage will start 6 months back from the date Social Security determines you're eligible. This is also required by law. You can't pick your free Part A start date. The date free Part A begins is important if you contribute to a Health Savings Account (HSA) because you can’t deposit money in your HSA for 6 months before your Part A start date. If you contribute to your HSA after your Medicare coverage starts, you may have to pay a tax penalty.

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 which is from January 1–March 31 each year
- In limited situations, a Special Enrollment Period (see page 13)

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.

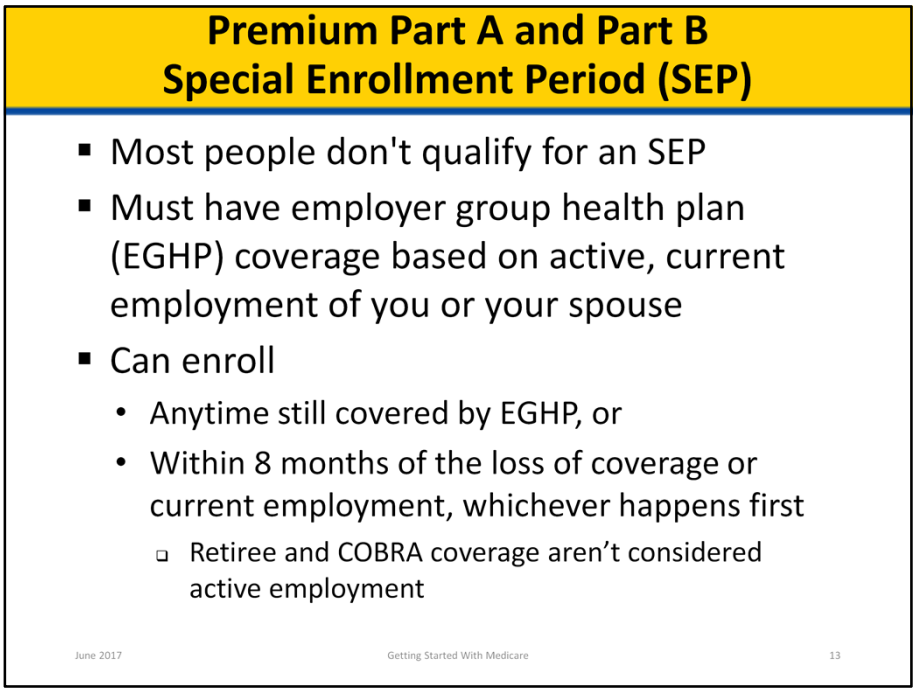


If you didn't sign up for Part B (or premium Part A) during your Initial Enrollment Period (IEP), you can enroll during the General Enrollment Period (GEP).

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's 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.



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.

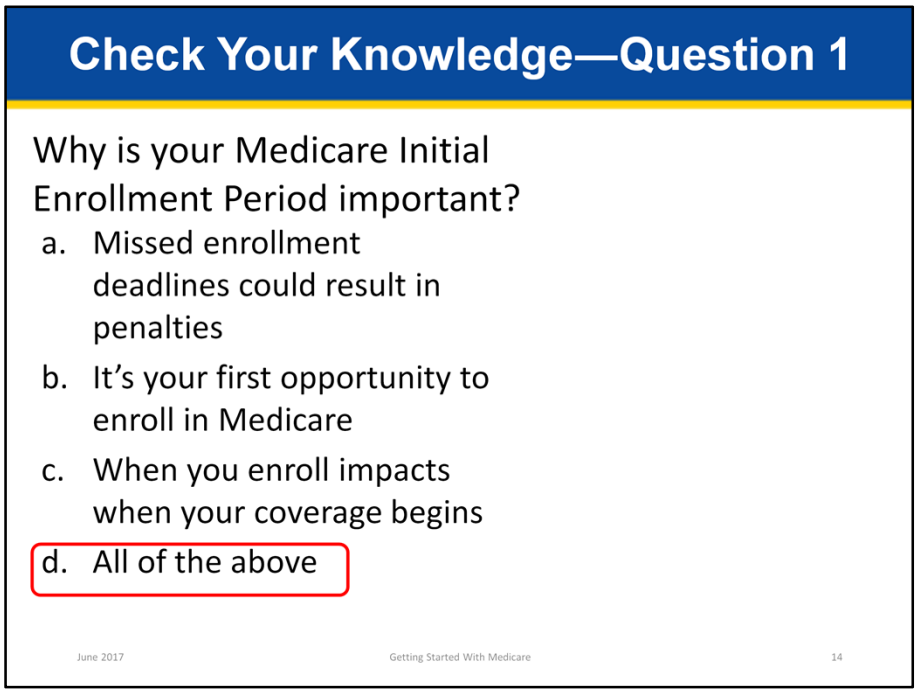
To be eligible, you must have employer group health plan (EGHP) coverage based on active, current employment. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a family member's current employment.

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 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.



Check Your Knowledge—Question 1

Why is your Initial Enrollment Period important?

a. Missed enrollment deadlines could result in penalties

b. It's your first opportunity to enroll in Medicare

c. When you enroll impacts when your coverage begins

d. All of the above

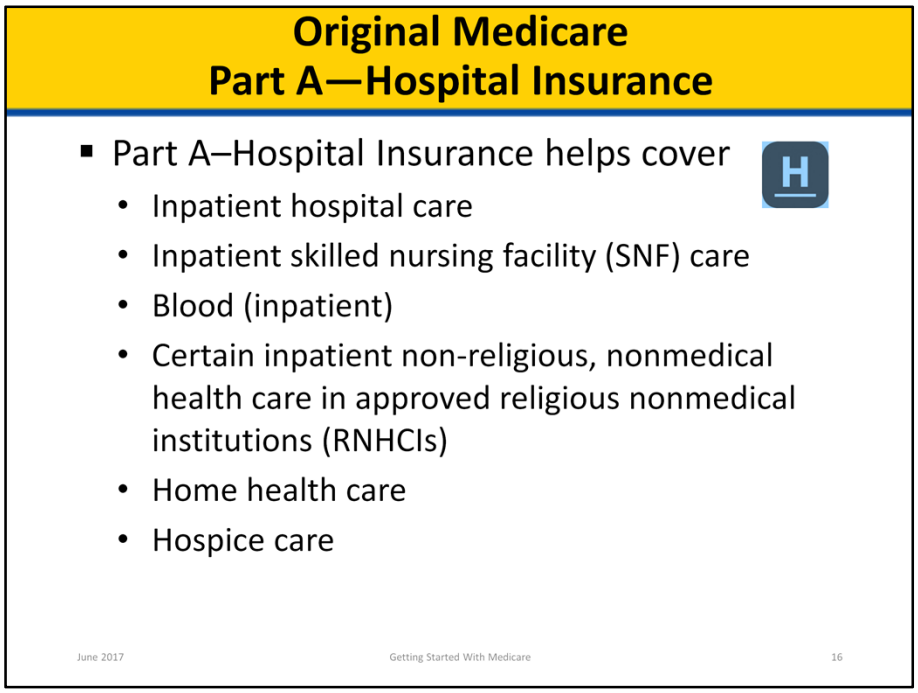
Answer: d. All of the above. The Initial Enrollment Period (IEP) is what becomes available to you when you first become eligible for Medicare and lasts for 7 months (3 months before your 65th birthday, the month of your birthday, and 3 months after your birthday). It's your first opportunity to enroll. When you sign up impacts the date your coverage starts and delaying enrollment after becoming eligible could result in lifelong penalties.

Lesson 2—Decision: How Do I Want to Get My Medicare Coverage?

- Original Medicare or Medicare Advantage?
- Should I take Part A and Part B? When?
- Do I need a Medigap policy?
- What about Part D?
- What do I need to do if I'm not retiring at 65?

There are some decisions you'll need to make about your Medicare coverage, including the following:

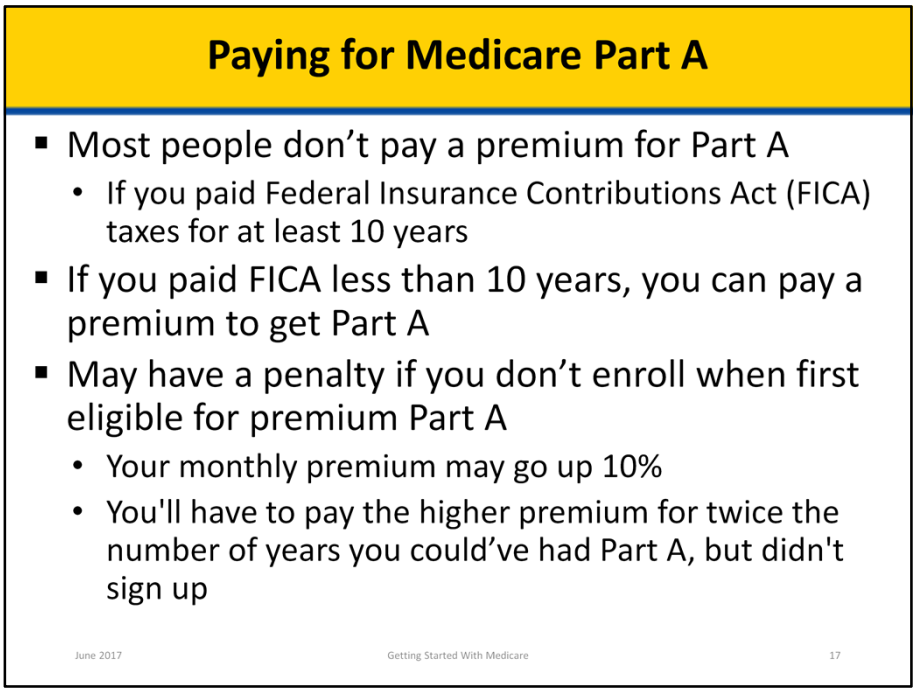
- Do I want Original Medicare or should I consider a Medicare Advantage Plan?
- Should I take Part A and Part B? When?
- Do I need a Medigap policy?
- What about Part D?
- What do I need to do if I'm not retiring at 65?



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; and 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.



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 worked 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 get 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

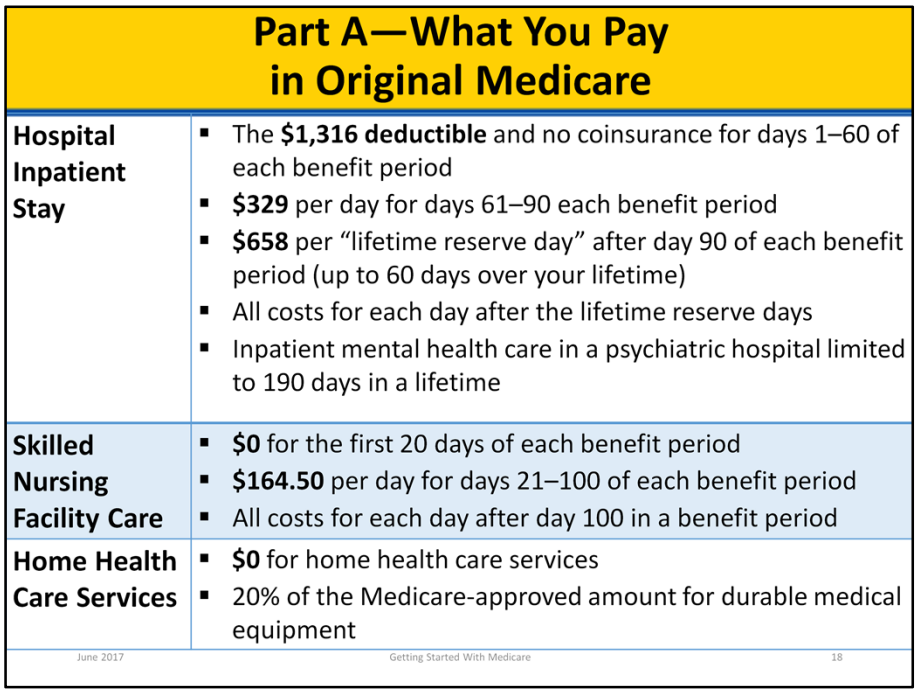
- 65 or older, and you have (or are enrolling in) Part B, and meet the citizenship and residency requirements.
- Under 65, have a disability, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and have a disability, you may continue to get premium-free Part 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.

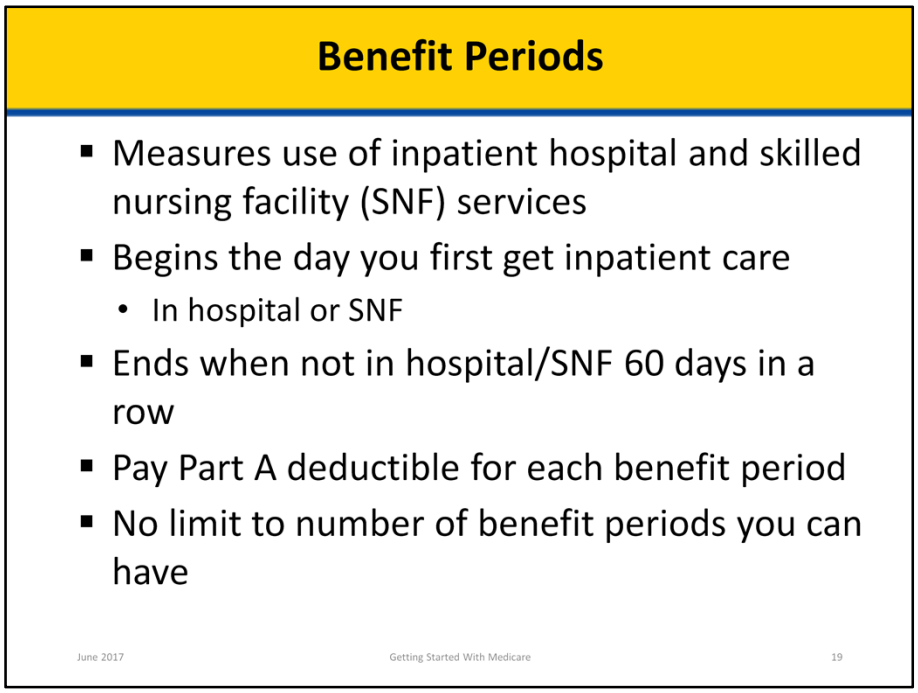


Part A—What You Pay in Original Medicare	
Hospital Inpatient Stay	▪ The **$1,316 deductible** and no coinsurance for days 1–60 of each benefit period ▪ **$329** per day for days 61–90 each benefit period ▪ **$658** per "lifetime reserve day" after day 90 of each benefit period (up to 60 days over your lifetime) ▪ All costs for each day after the lifetime reserve days ▪ Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime
Skilled Nursing Facility Care	▪ **$0** for the first 20 days of each benefit period ▪ **$164.50** per day for days 21–100 of each benefit period ▪ All costs for each day after day 100 in a benefit period
Home Health Care Services	▪ **$0** for home health care services ▪ 20% of the Medicare-approved amount for durable medical equipment

There are costs you pay in Original Medicare. The actual dollar amounts are updated yearly. To see the most current amounts, visit Medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html. This is what you pay per benefit period (discussed on the next page) for Part A–covered medically necessary services:

- Hospital Inpatient Stay: Medicare.gov/coverage/hospital-care-inpatient.html
  - The deductible amount for days 1–60, a fee for coinsurance per day for days 61–90, a fee per "lifetime reserve day" after day 90 of each benefit period* (up to 60 days over your lifetime); all costs for each day after the lifetime reserve days; Inpatient mental health care in a psychiatric hospital limited to 190 days in a lifetime
- Skilled Nursing Facility (SNF) Care: Medicare.gov/coverage/skilled-nursing-facility-care.html
  - $0 for first 20 days of each benefit period; a fee for coinsurance per day for days 21–100 of each benefit period; all costs after day 100 (See benefit periods on page 20)
- Home Health Care Services: Medicare.gov/coverage/home-health-services.html
  - $0 for home health care services
  - 20% of the Medicare-approved amount (coinsurance) for durable medical equipment for providers accepting assignment (must use a contract provider if in a Competitive Bidding Area)

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

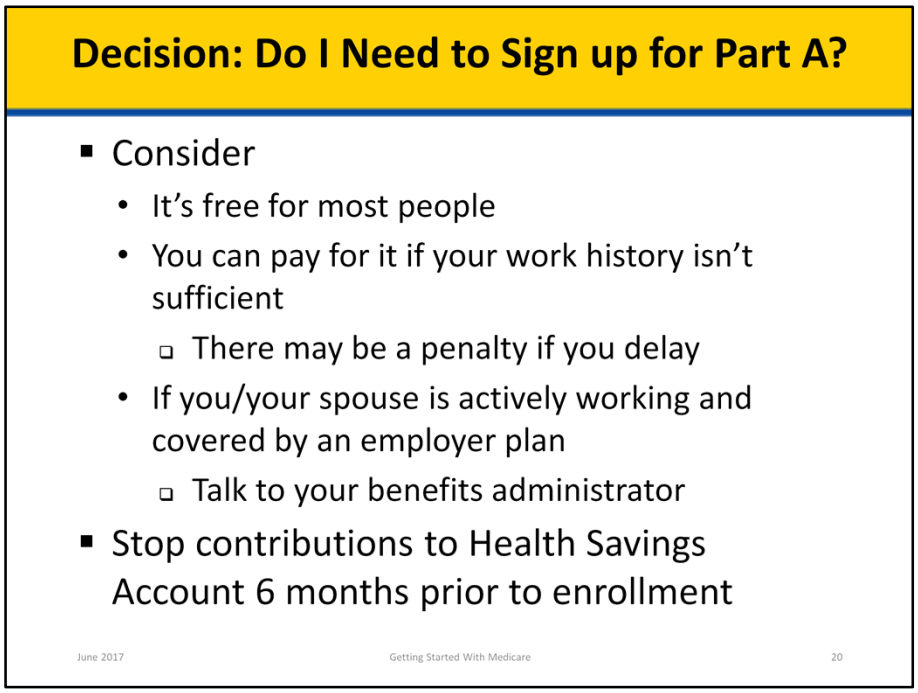


A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) 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 Part A inpatient hospital deductible 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 have 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 have returned home after being an inpatient in the hospital or in a combination of hospital and 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 SNF services, you must have 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.

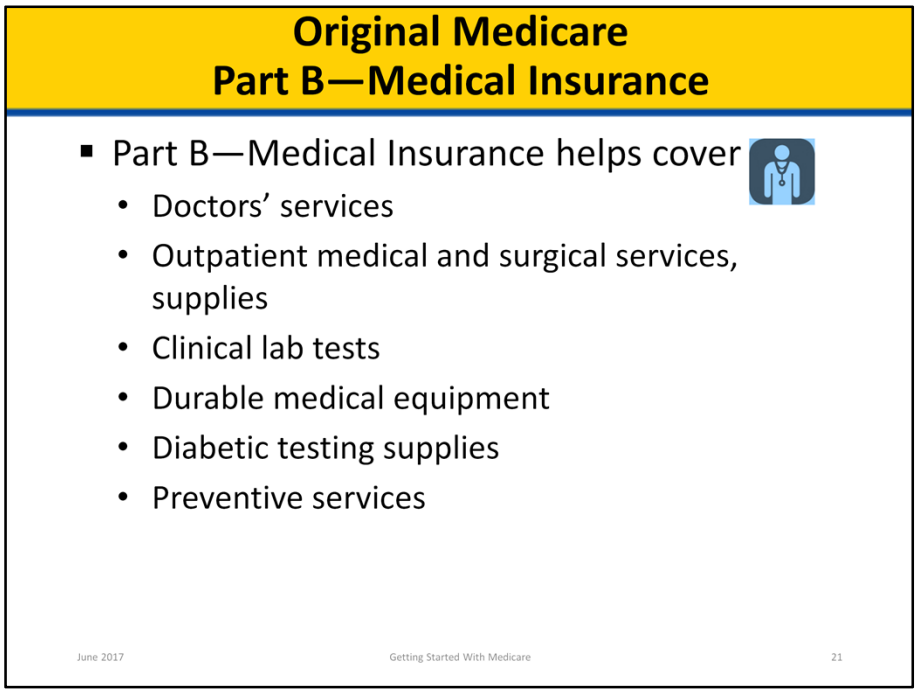


If you're receiving Social Security or Railroad Retirement Benefits at least 4 months before you turn 65, you'll be automatically enrolled in free Part A.

If you don't get Part A automatically, you should consider signing up for Part A when you're first eligible (during your IEP). Most people don't pay a monthly premium for Part A coverage because they or their spouse paid Medicare taxes while working.

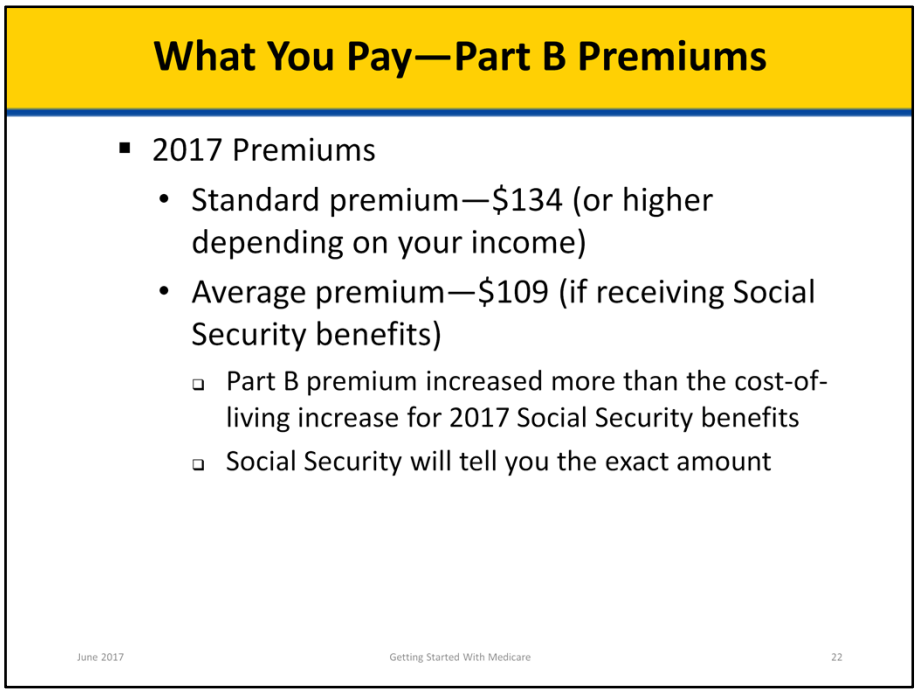
If you aren't eligible for free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10% for every 12 months you didn't have the coverage. You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up. The 10% premium surcharge will apply only after 12 months have elapsed from the last day of the IEP to the last date of the enrollment period you used to enroll. In other words, if it's less than 12 months, the penalty won't apply. This penalty also won't apply to you if you're eligible for a Special Enrollment Period (SEP). Remember, you're only eligible for an SEP if you or your spouse (or family member if you're disabled) is actively 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.

If you're still working or have coverage through a spouse, talk to your employer benefits coordinator to learn how enrolling in Medicare (or delaying enrollment) will affect your employer coverage. You can no longer contribute to a Health Savings Account (HSA) if you have Medicare. Talk to your company's benefits administrator about when you should stop contributing to an HSA if you plan to sign up for Medicare. You may have to stop contributing to your HSA up to 6 months before your Medicare starts. You can withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses (like deductibles, premiums, copayments). If you contribute to your HSA after you have Medicare, you could be subject to a tax penalty by the IRS. See IRS Publication 969 for more information: IRS.gov/pub/irs-pdf/p969.pdf.



Medicare Part B 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.



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 may pay less ($109 on average). Social Security will tell you the exact amount you will pay for Part B in 2017.

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.

You'll pay the standard premium ($134.00 or higher) in 2017 if you:

- Enroll in Part B for the first time in 2017
- Don't get Social Security benefits
- Are directly billed for your Part B premiums
- Have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $134.)
- Had a 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 (see next page).

Monthly Part B Standard Premium—Income-Related Medicare Adjustment Amount for 2017

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

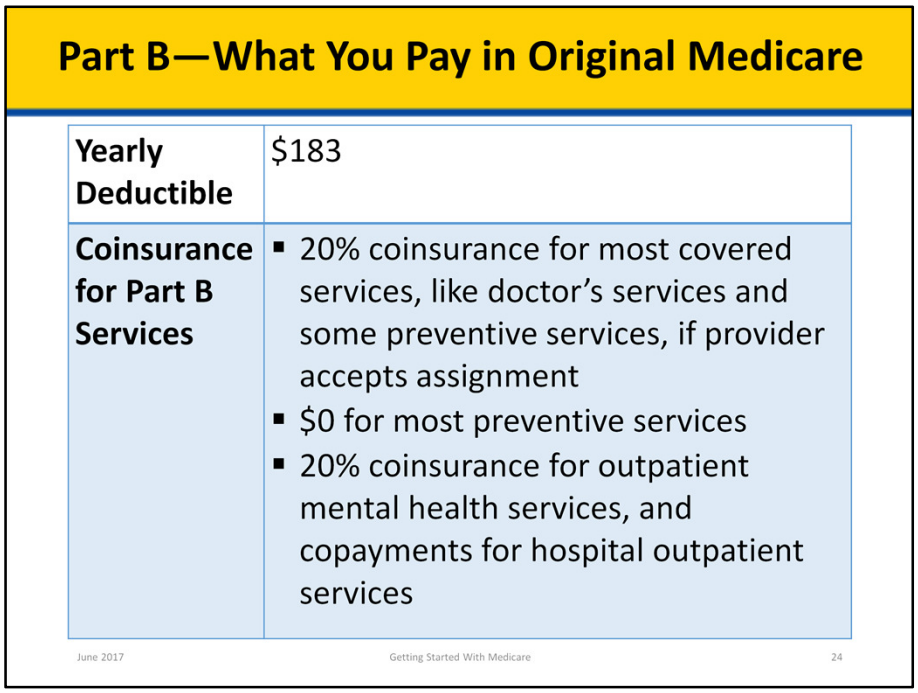
NOTE: You may pay more if you have a Part B late enrollment penalty.

Since 2007, people with Medicare with higher incomes have paid higher Medicare Part B monthly premiums. These income-related monthly premium rates affect roughly 5% of people with Medicare. The total Medicare Part B premiums for people with high income for 2017 are shown in the following table:

For those whose income is

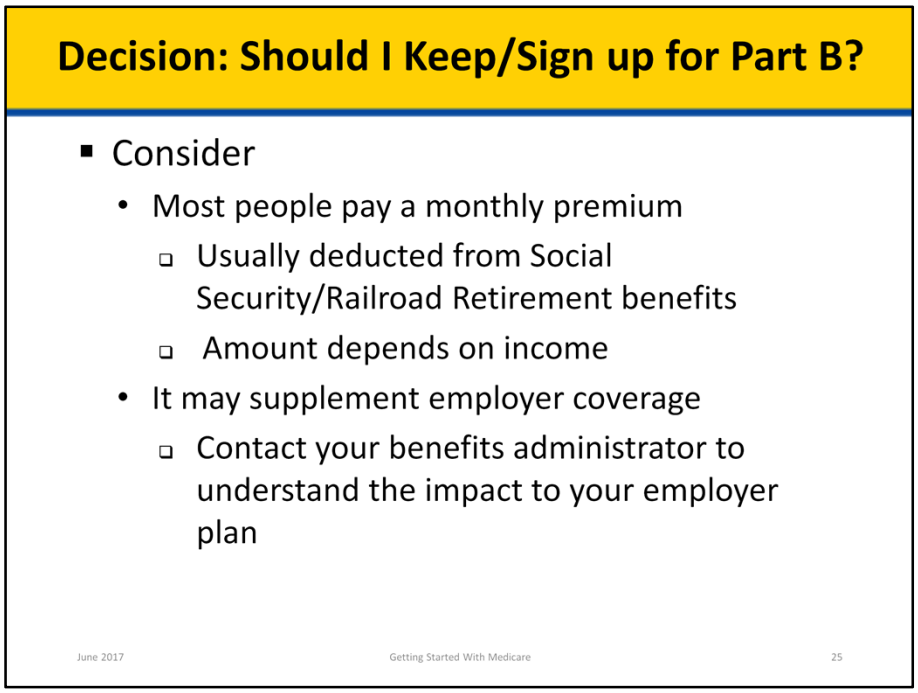
- $85,000 or less, and file an individual tax return, file a joint tax return with a yearly income of $170,000 or less, or file married with separate tax returns, the Part B premium is $134.00 per month.
- $85,000.01–$107,000, and file an individual tax return, file a joint tax return with a yearly income above $170,000 up to $214,000, or file married with separate tax returns, the Part B premium is $187.50 per month
- $107,000.01–$160,000, and file an individual tax return, file a joint tax return with a yearly income of above $214,000 up to $320,000, or file married with a separate tax return, the Part B premium is $267.90 per month
- $160,000.01–$214,000, and file an individual tax return, file a joint tax return with an income above $320,000 up to $428,000, or file married with separate tax returns with an income above $85,000 and up to $129,000, the Part B premium is $348.00 per month
- Above $214,000, and file an individual tax return, file a joint tax return with an income above $428,000, or file married and file separate tax return with an income above $129,000, the Part B premium is $428.60 per month

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



In addition to premiums, there are other costs you pay in Original Medicare. This is what you pay in 2017 for Part B covered medically necessary services:

- The annual Part B deductible is $183 in 2017. If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. This means that you must pay the first $183 of your Medicare-approved medical bills in 2017 before Part B starts to pay for your care.
- Coinsurance for Part B services. In general, it's 20% for most covered services for providers accepting assignment.
- Most preventive services have no coinsurance, and the Part B deductible doesn't apply as long as the provider accepts assignment. An assignment is an agreement between Medicare and health care providers and suppliers to accept the Medicare-approved amount as payment in full. You pay the deductibles and coinsurance (usually 20% of the approved amount). If assignment isn't accepted, providers can charge you up to 15% above the approved amount (called the "limiting charge"), and you may have to pay the entire amount up front. Covered services include medically necessary doctor's services; outpatient therapy such as physical therapy, speech therapy, and occupational therapy subject to limits; most preventive services; durable medical equipment; and blood received as an outpatient that wasn't replaced after the first 3 pints.
- You pay 20% for outpatient mental health services (visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions, or outpatient treatment of your condition [like counseling or psychotherapy] for providers accepting assignment).
- If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation.

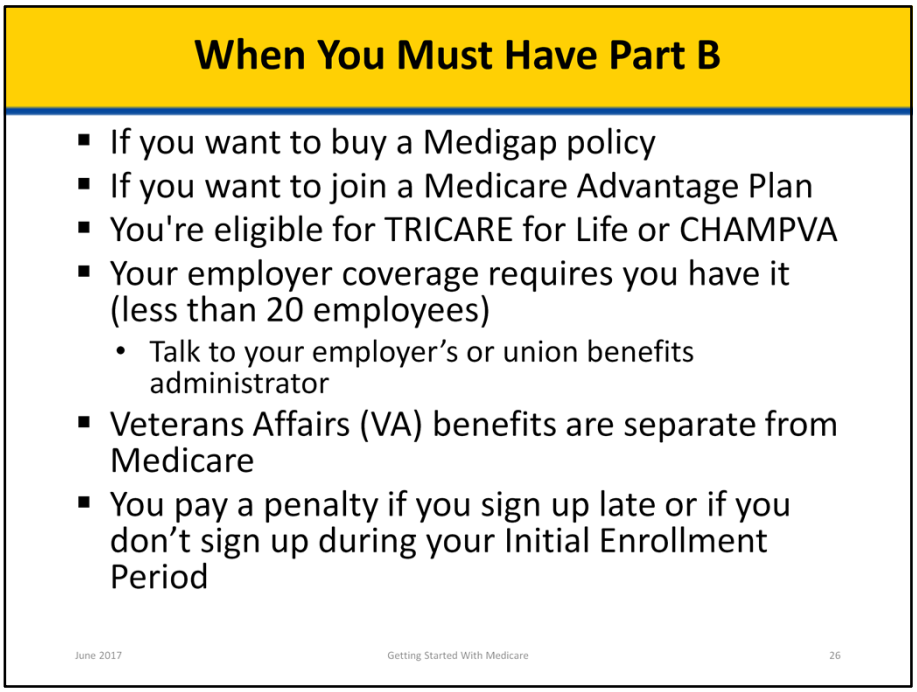


If you're already getting Social Security benefits (for example, getting early retirement) at least 4 months before you turn 65, you'll automatically be enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period (IEP) package, which includes your 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).

The Part B premium is usually deducted from monthly Social Security, Railroad Retirement, or federal retirement payments. The amount depends on your income and when you enroll in Part B. If you delay enrollment, you may have to pay a lifetime penalty, which is added to your monthly Part B premium.

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

Having employer or union coverage while you or your spouse, or family member if you're disabled, is still working can affect your Part B enrollment rights. This includes federal and state employment, and TRICARE active-duty military service. You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if you should enroll in Part B during your IEP.



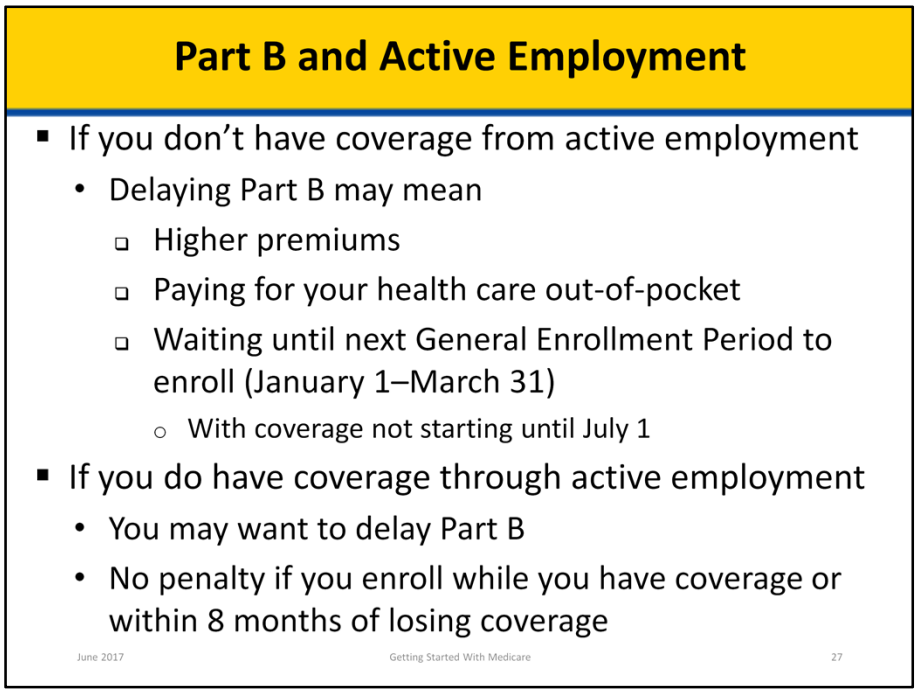
You must have Part B if

- 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). 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 SEP if you have Medicare because you're 65 or older, or you're disabled. For more information, visit Tricare.mil/mybenefit.
- Your employer coverage requires you or your spouse/family member to have it—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).

You must have Part A and Part B to keep your CHAMPVA coverage. For more information, visit va.gov/PURCHASEDCARE/programs/dependents/champva/CHAMPVA_eligibility.asp.

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

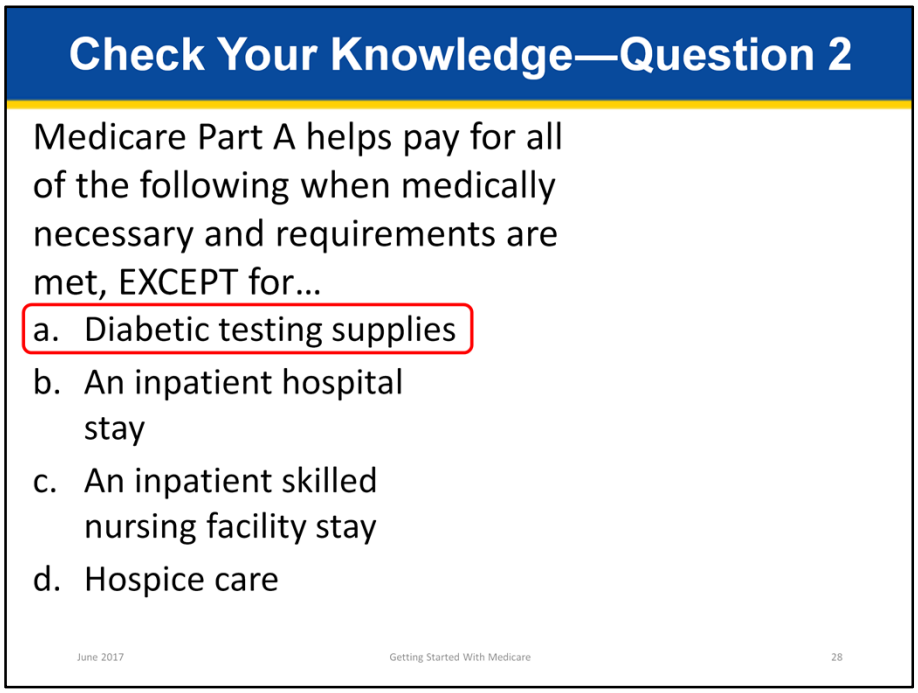


If you don't take Part B when you're first eligible, you'll have to pay a premium penalty of 10% for each full 12-month period you could have had Part B but didn't sign up for it, except in special situations. In most cases, you'll have to pay this penalty for as long as you have Part B.

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

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 or your spouse are covered through active employment, 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 an SEP. This SEP doesn't apply to people with End-Stage Renal Disease (ESRD).

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



Check Your Knowledge—Question 2

Medicare Part A helps pay for all of the following when medically necessary and requirements are met, EXCEPT for?

a. Diabetic testing supplies

b. An inpatient hospital stay

c. An inpatient skilled nursing facility stay

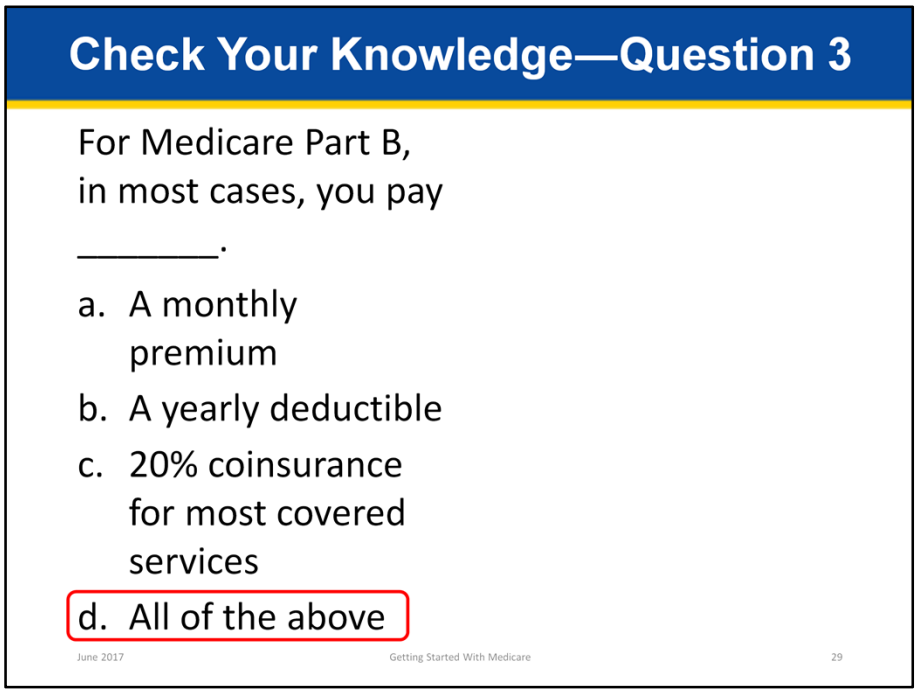
d. Hospice care

Answer: a. Diabetic testing supplies. Medicare Part A covers inpatient care (hospital and skilled nursing facility) and hospice care. Diabetic Testing Supplies could be covered under Medicare Part B (Medical Insurance), including

- Blood sugar (glucose) test strips
- Blood sugar testing monitors
- Insulin
- Lancet devices and lancets
- Glucose control solutions
- Therapeutic shoes or inserts

You may need to use specific suppliers for some types of diabetic testing supplies. Visit Medicare.gov/supplierdirectory/search.html.

In some cases, certain diabetic testing supplies could also be covered under Medicare Part D.



Check Your Knowledge—Question 3

For Medicare Part B, in most cases, you pay _____.

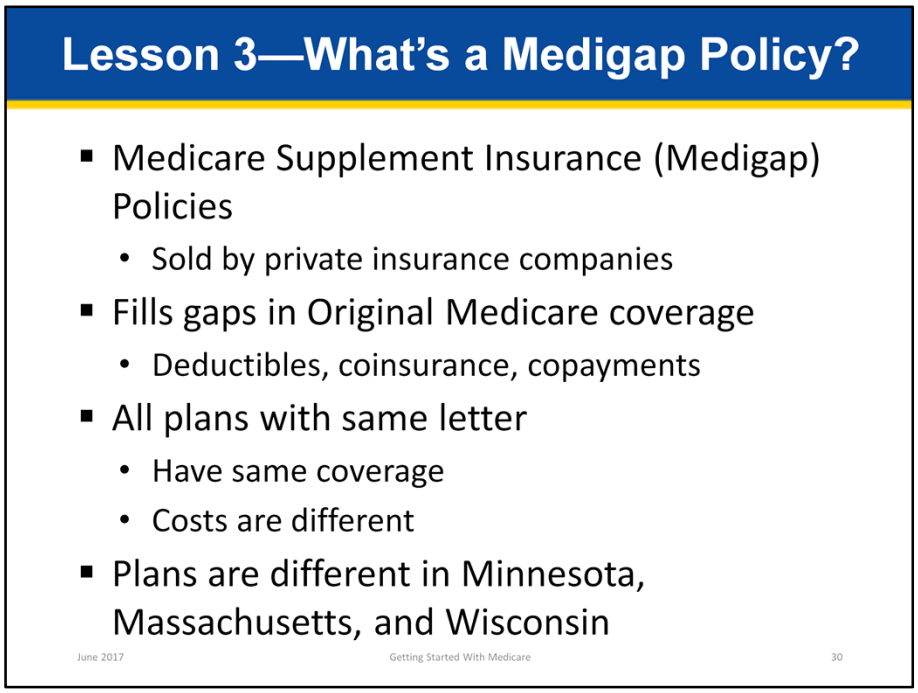
a. A monthly premium

b. A yearly deductible

c. 20% coinsurance for most covered services

d. All of the above

Answer: d. All of the above. For Medicare Part B, most people will pay a monthly premium, the Part B yearly deductible, and 20% coinsurance for most covered services. These Part B amounts change yearly.



Now let's talk about one way to help address some of the costs associated with Original Medicare coverage. A Medigap policy is health insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies can help pay your share (coinsurance, copayments, or deductibles) of the costs of Medicare-covered services. Some Medigap policies also cover certain benefits Original Medicare doesn't cover.

Medigap policies don't cover your share of the costs under other types of health coverage, including Medicare Advantage Plans, stand-alone Medicare Prescription Drug Plans, employer/union group health coverage, Medicaid, Department of Veterans Affairs benefits, or TRICARE.

In all states except Massachusetts, Minnesota, and Wisconsin, Medigap policies must be one of the standardized Plans A, B, C, D, F, G, K, L, M, or N so they can be easily compared. Each plan has a set of benefits that are the same for any insurance company. It's important to compare Medigap policies, because costs can vary. Each company decides which Medigap policies it will sell and the price for each plan, with state review and approval. Other differences include pre-existing conditions waiting period, crossover of claims from Medicare Administrative Contractor to Medigap policy, guarantee issue, etc.

For more information on Medigap, see Module 3 in the Training Library: CMS.gov/Outreach-and-Education/ Training/CMSNationalTrainingProgram/Training-Library.html.

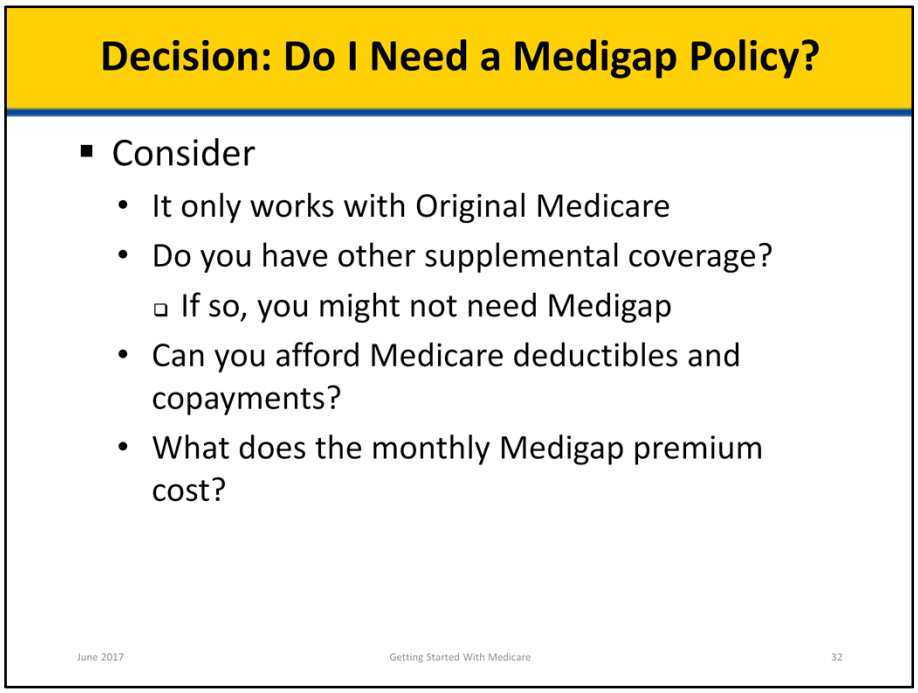
Medigap Plan Types

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	50%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	100%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2017**							$5,120	$2,560		

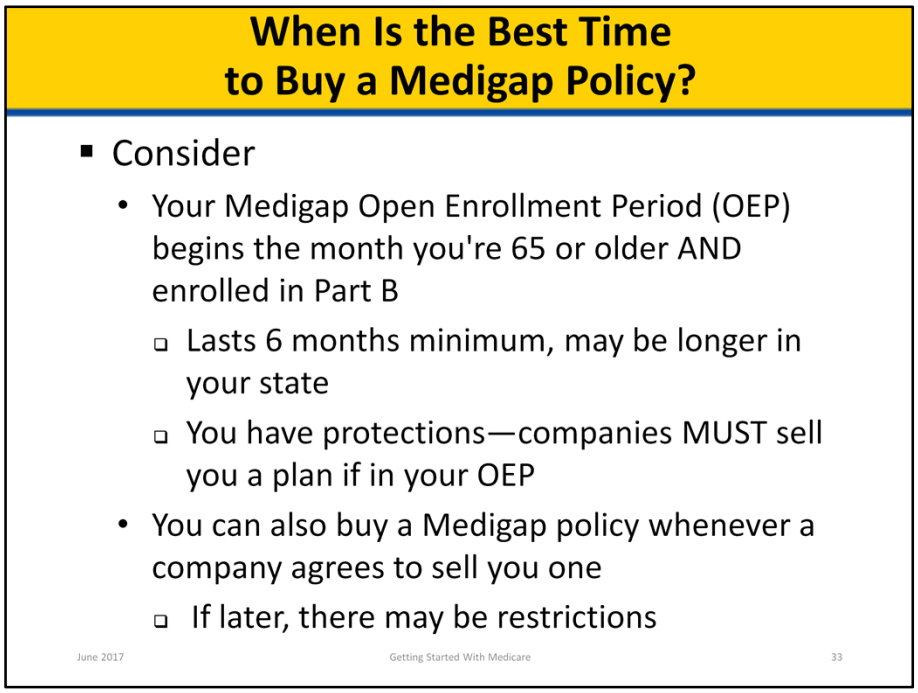
*Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,200 in 2017 before your policy pays anything.
**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2017), the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

All Medigap policies cover a basic set of benefits, including the following:

- All plans cover 100% of Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up.
- Medicare Part B coinsurance or copayment, with Plans A, B, C, D, F, G, M, and N covering 100%. Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits, and up to a $50 copayment for emergency room visits that don't result in an inpatient admission. Plan K pays 50% of Medicare Part B coinsurance or copayment, with Plan L paying 75%.
- Blood (first 3 pints) with Plans A, B, C, D, F, G, M, and N covering 100%; Plan K 50%; and Plan L 75%.
- Part A hospice care coinsurance or copayment with Plans A, B, C, D, F, G, M, N covering 100%; Plan K 50%; and Plan L 75%.
- In addition, each Medigap plan covers different benefits:
  - The skilled nursing facility care coinsurance is covered 100% by Plans C, D, F, G, M, and N covering 100%; Plan K 50%; and Plan L 75%.
  - The Medicare Part A deductible is covered 100% by Plans B, C, D, F, G, and N; Plans K and M 50%; and Plan L 75%.
  - The Medicare Part B deductible is 100% covered by Medigap Plans C and F.
  - The Medicare Part B excess charges are covered 100% by Medigap Plans F and G.
  - Foreign travel emergency costs up to the plans' limits are covered at 80% by Medigap Plans C, D, F, G, M, and N.
  - In 2017, Plans K and L have out-of-pocket limits of $5,120 and $2,560, respectively.
  - Plan F also offers a high-deductible plan in some states.



- You need to have Original Medicare to get a Medigap policy; Medigap doesn't work with Medicare Advantage.
- If you have other coverage that supplements Medicare, such as retiree coverage, you might not need Medigap.
- You need to consider whether you can afford Medicare deductibles and copayments and weigh this against how much the monthly Medigap premium costs.



Usually the best time to buy a Medigap policy is during your Medigap Open Enrollment Period (OEP). It begins when you're 65 or older and enrolled in Part B for the first time. You must also have Medicare Part A to have a Medigap policy.

You have a 6-month Medigap OEP, which gives you a guaranteed right to buy a Medigap policy. Some states may have a longer period. Once this period starts, it can't be delayed or repeated.

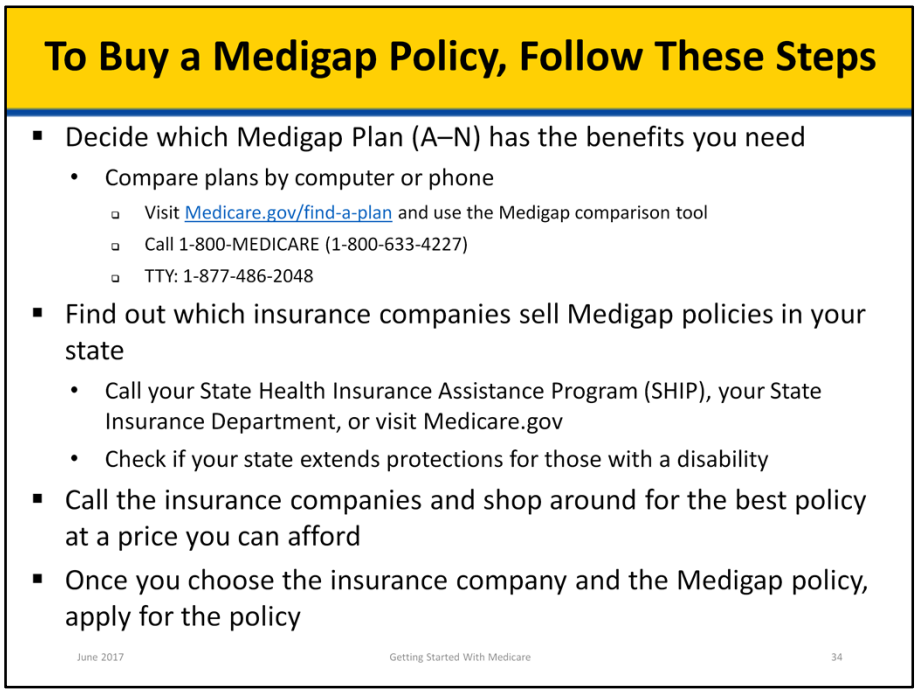
During your Medigap OEP, companies can't do the following:

- Refuse to sell you any Medigap policy they offer
- Make you wait for coverage (there can be a waiting period for pre-existing conditions if you don't have creditable coverage before the OEP)
- Charge more because of a past/present health problem

You may want to apply for a Medigap policy before your Medigap OEP starts if your current health insurance ends the month you become eligible for Medicare, or you reach 65, to have continuous coverage without any break.

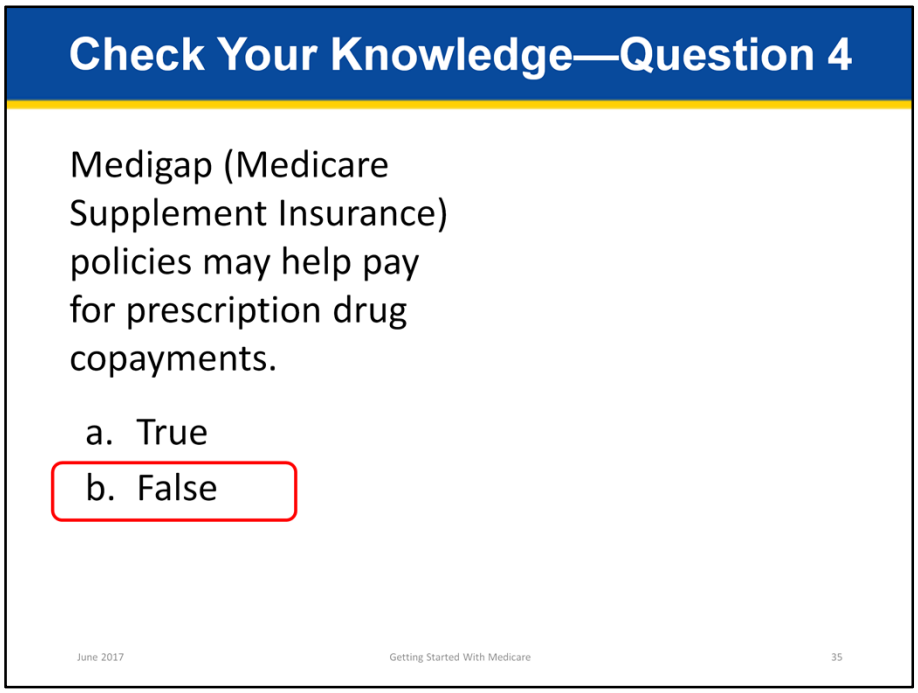
You can also buy a Medigap policy whenever a company agrees to sell you one. However, there may be restrictions, such as medical underwriting or a waiting period for pre-existing conditions.

Medical underwriting is a process used by insurance companies to try to figure out your health status when you're applying for health insurance to determine whether to offer you coverage, at what price, and with what exclusions or limits.



To buy a Medigap policy, follow these steps:

- Decide which Medigap Plan (A–N) has the benefits you need. You can use the Medigap comparison tool on Medicare.gov/find-a-plan to compare your plans or by calling 1-800-633-4227; TTY: 1-877-486-2048.
- Find out which insurance companies sell Medigap policies in your state by calling your State Health Insurance Assistance Program, your State Insurance Department, or visit Medicare.gov/find-a-plan.
- Federal Medigap protections aren't offered for people with Medicare due to a disability, so contact your State Insurance Department to determine if your state extends protections to people under 65.
- Call the insurance companies and shop around for the best policy at a price you can afford.
- Buy the Medigap policy. Once you choose the insurance company and the Medigap Plan, apply for the policy. The insurance company must give you a clearly worded summary of your Medigap policy when you apply.



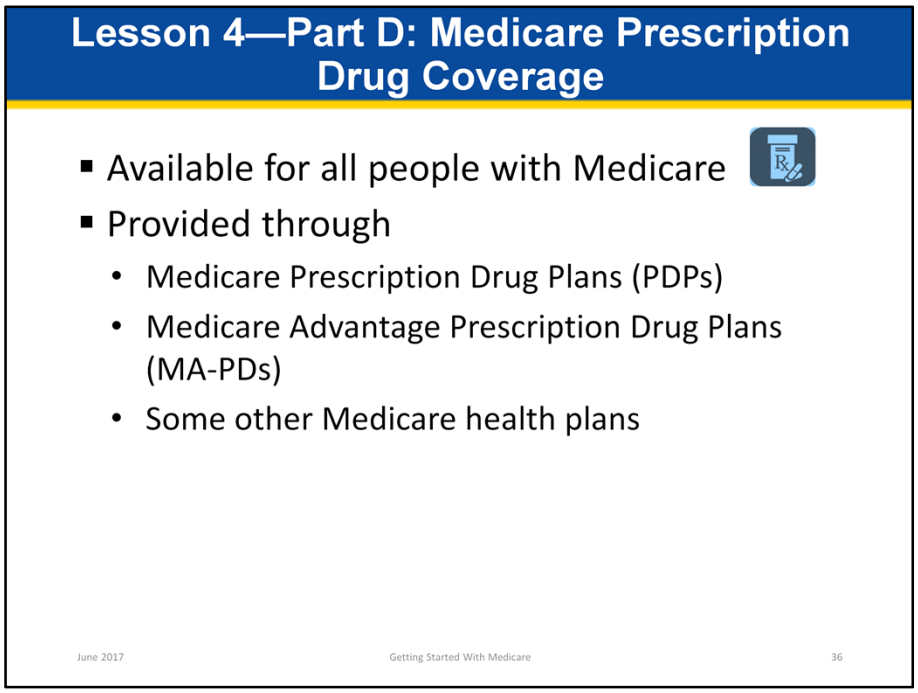
Check Your Knowledge—Question 4

Medigap (Medicare supplement insurance policies) may help pay for prescription drug copayment.

a. True

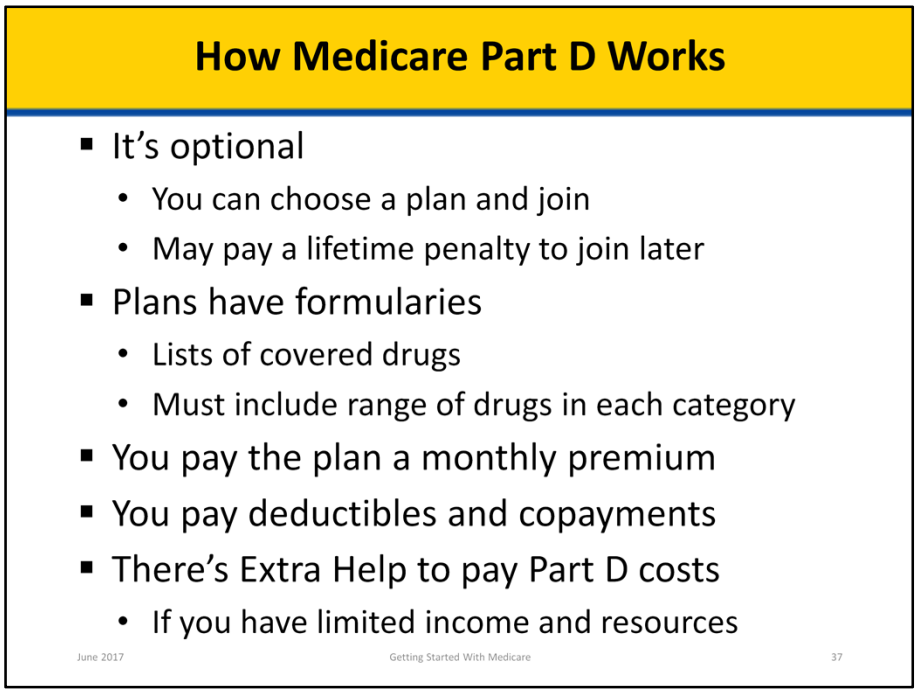
b. False

Answer: b. False. Medicare supplement insurance policies (Medigap) covers gaps in Original Medicare coverage, like deductibles, coinsurance, and copayments for Medicare covered services.



Medicare Part D is Medicare Prescription Drug Coverage. Part D coverage is provided through Medicare Prescription Drug Plans (PDPs) and Medicare Advantage (MA) Plans with Medicare prescription drug coverage.

There are some other types of Medicare health plans that provide health care coverage which aren't Medicare Advantage Plans, but are still part of Medicare, such as Medicare Cost Plans and Programs of All-Inclusive Care for the Elderly (PACE). Some of these plans provide Medicare Part A and Part B coverage, while others provide Part B coverage only. Some also provide Part D. These plans have some of the same rules as MA Plans as you will see later in this presentation. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.



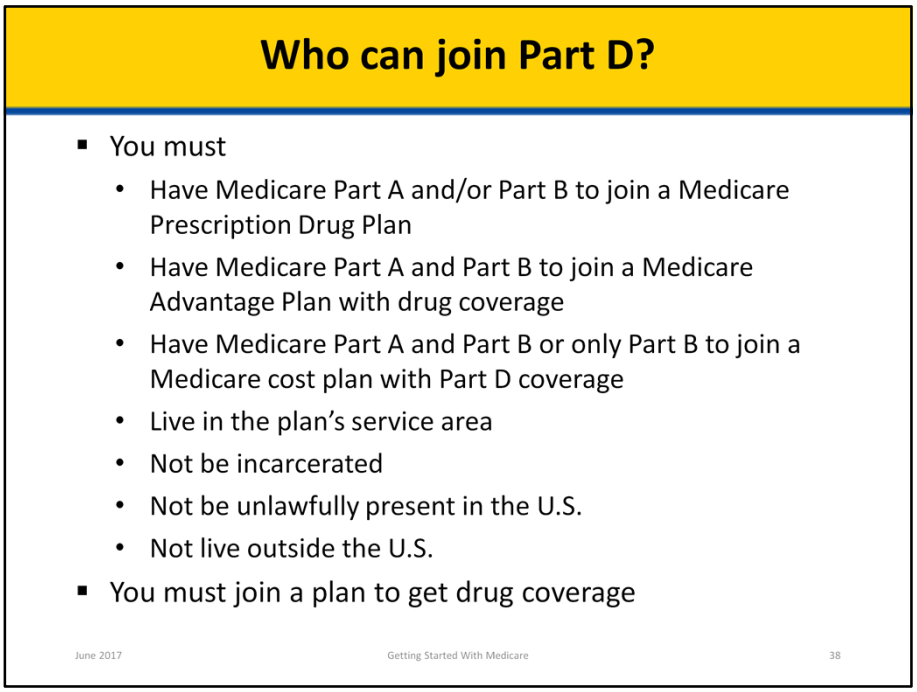
Medicare contracts with private insurance companies that offer prescription drug plans to people with Medicare. Everyone with Medicare can get Medicare prescription drug coverage by enrolling in a Medicare drug plan. You may pay a penalty if you join later. You may get this coverage from a Medicare Advantage Plan (with prescription drug coverage), but you must have Part A and Part B.

Each plan has a formulary, or list of covered drugs. The formulary for each plan must include a range of drugs in the most commonly prescribed categories. This makes sure that people with different medical conditions can get the treatment they need. All Medicare drug plans generally must cover at least 2 drugs in each category of drugs, but plans can choose which specific drugs are covered in each category.

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

If you have Medicare prescription drug coverage (Part D) and a higher yearly income, you might also have to pay Part D Income-Related Monthly Adjustment Amount (IRMAA). If you have to pay this extra amount for Medicare Part D, the amount will be deducted from your Social Security or Railroad Retirement Board benefit or you'll be billed monthly by Medicare. If you get a bill for Part D IRMAA, you pay this amount to Medicare, not your Part D plan.

People with limited income and resources may be able to get Extra Help paying for their Medicare drug plan costs. "Extra Help" is discussed in further detail on page 60.

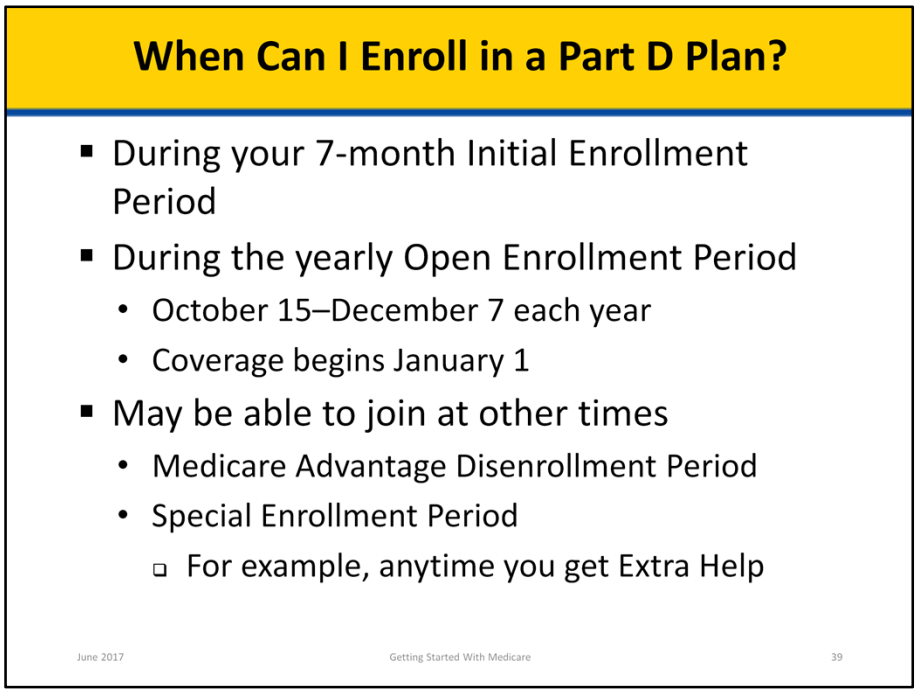


In general, you are eligible to enroll in a Medicare prescription drug plan (PDP) if you

- Are enrolled in Medicare Part A and/or Part B,
- Permanently reside in the service area of a PDP
- Are a U.S. citizen or lawfully present in the United States

If you are living abroad or are incarcerated, you aren't eligible for Part D because you cannot 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.



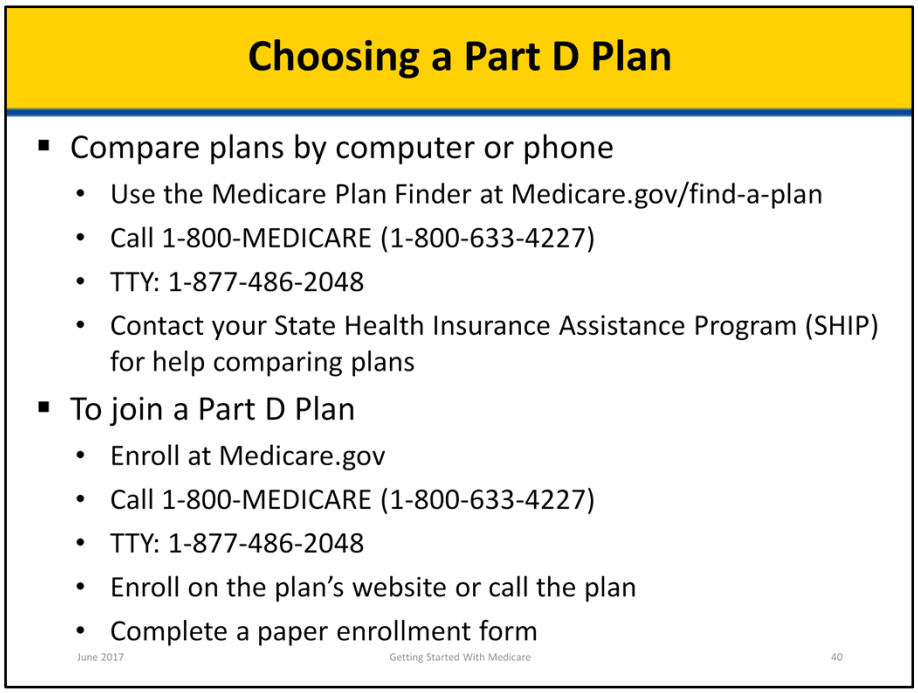
You can join a Medicare drug plan when you first become eligible for Medicare, during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B.

The annual election period/**Open Enrollment Period (OEP)**—This period is from October 15 through December 7. Any eligible person can join, switch, or drop a Medicare drug plan at this time. Each year, you have a chance to make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. Your coverage starts January 1. For most people, this is the one time each year that changes can be made. If you make a change during this time, your new coverage starts on January 1 if the plan gets your request by December 7. Generally, your enrollment will begin the first of the month after the plan gets your enrollment request.

Generally you must stay enrolled for the calendar year. However, in certain situations you may join at other times, such as when you switch from Medicare Advantage (during the disenrollment period) to Original Medicare, you may add Part D coverage. You may also be eligible for a Special Enrollment Period (SEP), which may allow you to join, switch, or drop Medicare drug plans if one of the following is true:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage ("creditable" means coverage that's considered at least as good as Medicare prescription drug coverage)
- If you weren't adequately informed that your other coverage wasn't creditable, or that the coverage was reduced so that it's no longer creditable
- When you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help (you have a continuous SEP and can change your Medicare drug plan at any time)
- Or in exceptional circumstances, such as if you no longer qualify for Extra Help

Visit Medicare.gov/Publications/Search/Results.asp for "Understanding Medicare Part C & D Enrollment Periods."

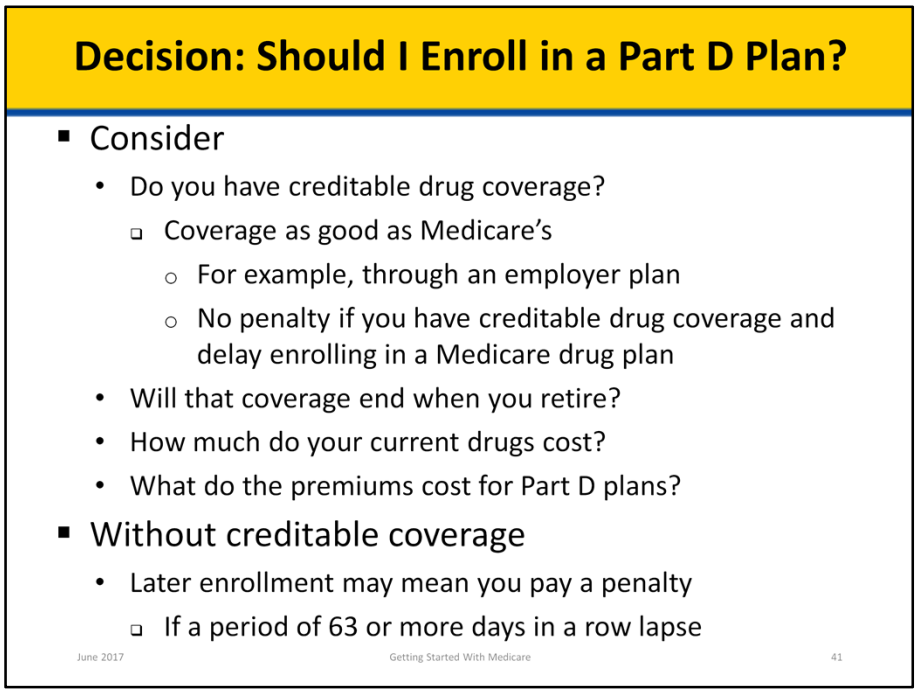


There's help available to find the Medicare drug plan for you. You can use the Medicare Plan Finder at Medicare.gov/find-a-plan/, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048, or contact your State Health Insurance Assistance Program (SHIP) at shiptacenter.org/ for free counseling to help you compare Medicare drug plans.

After you pick a plan that meets your needs, call the company offering it, and ask how to join. All plans must offer paper enrollment applications. Also, plans may let you enroll through their website or over the phone. Most plans also participate and offer enrollment through Medicare.gov. You can also call Medicare to enroll at 1-800-MEDICARE. TTY: 1-877-486-2048.

Plans must process applications in a timely manner, and after you apply, the plan must notify you that it has accepted or denied your application. Plans aren't allowed to deny your application based on your health condition or the drugs you're taking.

NOTE: Medicare.gov/contacts/ can provide SHIP contact information nationwide.

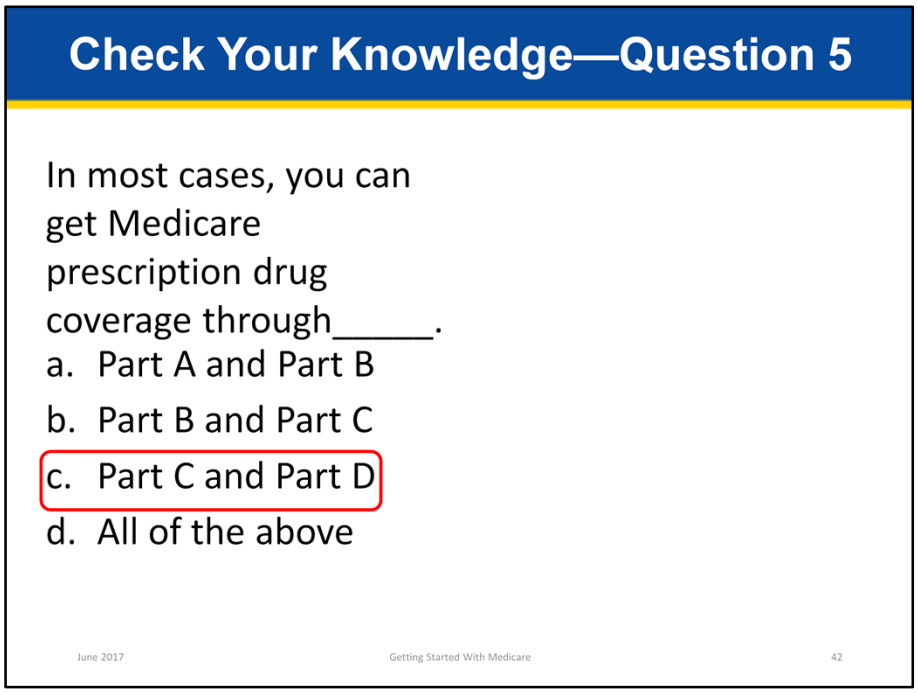


People who have another source of drug coverage, through a former employer for example, may choose to stay in that plan and not enroll in a Medicare drug plan. If your other coverage is at least as good as Medicare prescription drug coverage, called "creditable" coverage, you won't have to pay a higher premium if you later join a Medicare drug plan. Your other plan will notify you to let you know if your coverage is creditable. This notice will explain your options. You can contact your plan's benefits administrator for more information. Some examples of coverage that may be considered creditable include group health plans (GHPs), Federal Employees Health Benefits (FEHB), State Pharmaceutical Assistance Programs (SPAPs), Veterans Affairs coverage, and military coverage, including TRICARE.

Even if you don't take many prescriptions now, you should consider joining a Medicare drug plan. If you decide not to join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage, or you don't get Extra Help, you'll likely pay a late enrollment penalty if you join a plan later.

You may owe a late enrollment penalty if, at any time after your Initial Enrollment Period 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. The cost of the late enrollment penalty depends on how long you went without creditable prescription drug coverage.

Currently, the late enrollment penalty is calculated by multiplying 1% of the national base beneficiary premium ($35.63 in 2017) times the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the national base beneficiary premium may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan.



Check Your Knowledge–Question 5

In most cases, you can get Medicare prescription drug coverage through_____.

a. Part A and Part B

b. Part B and Part C

c. Part C and Part D

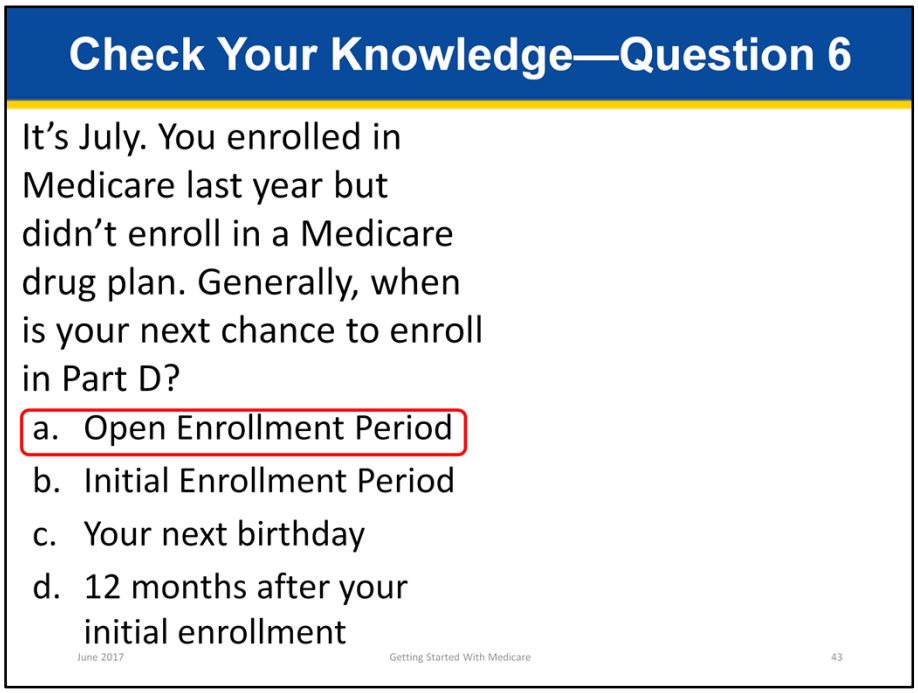
d. All of the above

Answer: **c. Part C and Part D**

In most cases, there are 2 ways to get drug coverage depending on how you get your Medicare benefits. Part D coverage is provided through Medicare Prescription Drug Plans, and Part C Medicare Advantage (MA) Plans with Medicare prescription drug coverage (MA-PD).

If you have

- Original Medicare you can select a stand-alone PDP if you want to continue to get your other health benefits through Original Medicare.
- An MA Plan (such as an HMO or PPO), generally, you must get Part D drug coverage as part of your MA Plan's benefits package. If you join a Medicare Medical Savings Accounts, Private Fee-for-Service plan, or a Cost Plan, you can also join a PDP if drug coverage isn't already offered.



Check Your Knowledge—Question 6

It's July. You enrolled in Medicare last year but didn't enroll in a Medicare drug plan. Generally, when is your next chance to enroll in Part D?

a. Open Enrollment Period

b. Initial Enrollment Period

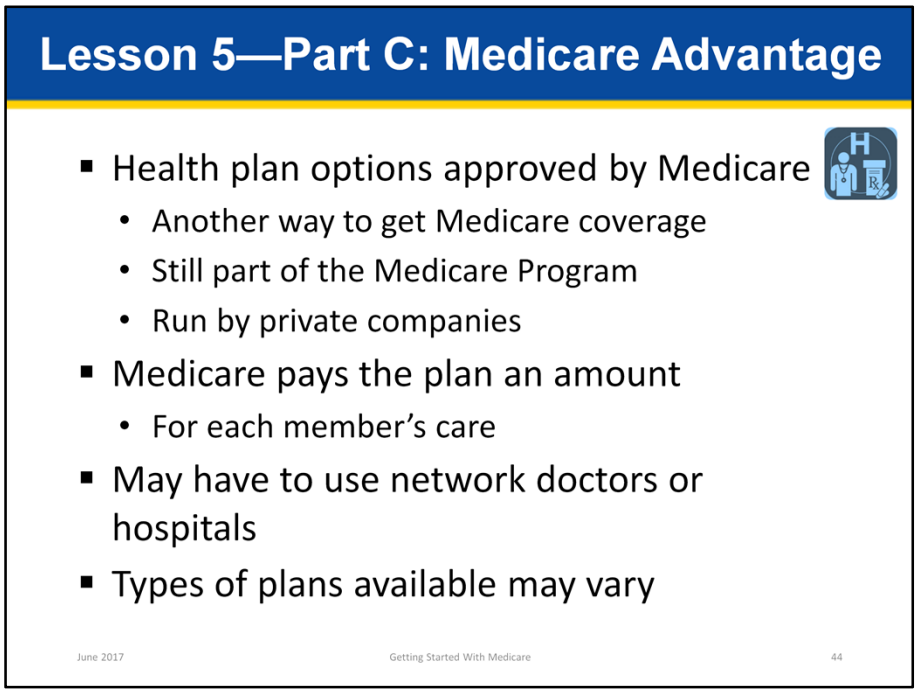
c. Your next birthday

d. 12 months after your initial enrollment

Answer: a. Open Enrollment Period

Generally, the soonest you could join a Part D Plan is the next Open Enrollment Period from October 15 through December 7. Each year, you have a chance to make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. For most people, this is the one time each year that changes can be made. If you make a change during this time, your new coverage starts on January 1.

NOTE: You may owe a late enrollment penalty if, at any time after your Initial Enrollment Period 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. The cost of the late enrollment penalty depends on how long you went without creditable prescription drug coverage.

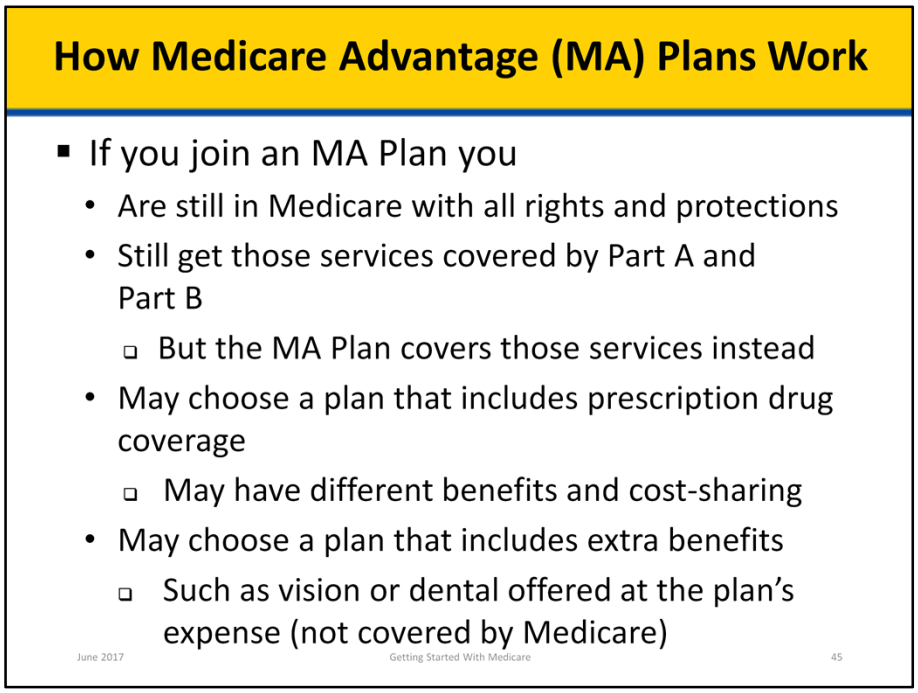


Medicare Advantage (MA) Plans (also called Part C Plans) are health plan options approved by Medicare and run by private companies. MA Plans are part of the Medicare Program; they're just another way to get Medicare coverage. Medicare pays the plan a certain amount for each member's care. If you join an MA Plan, you may have to use a network* of doctors and/or hospitals. There are 6 main types of MA Plans. Not all types of plans are available in all areas:

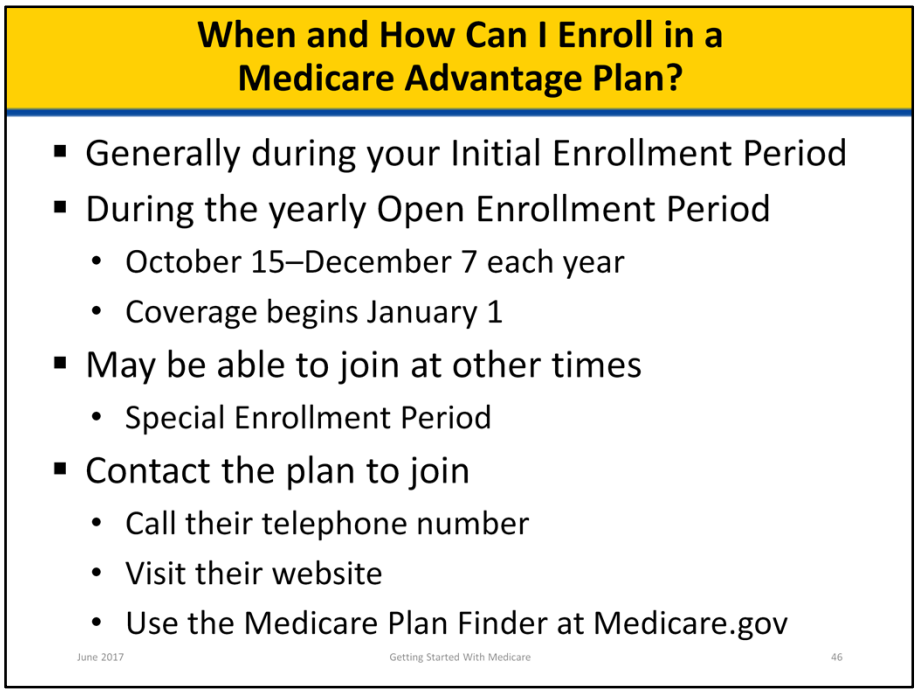
- Medicare Health Maintenance Organization (HMO) Plans—You get your care and services from doctors or hospitals in the plan's network. If you get care outside the plan network, you may have to pay the full cost.
- Medicare Preferred Provider Organization (PPO) Plans—You have a network of doctors and hospitals, but with a PPO plan, you can also use out-of-network providers for covered services, usually for a higher cost.
- Medicare Private Fee-for-Service (PFFS) Plans—You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.
- Medicare Special Needs (SNP) Plans—SNP Plans are designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network.
- HMO Point-of-Service (HMOPOS) Plans—In some HMO plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.
- Medicare Medical Savings Account (MSA) Plans—Plans that combine a high-deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services.

*Network—The facilities, providers, and suppliers your plan has contracted with to provide health care services.

PFFS and MSA plans aren't coordinated care plans, so an enrollee in these plan types won't necessarily have a network of providers or a provider to coordinate their care.



- If you join a Medicare Advantage (MA) Plan, you
  - Are still in Medicare with all rights and protections
  - Still get those services covered by Part A and Part B, but the MA Plan covers those services instead of Original Medicare (must have both Part A and Part B to join an MA Plan)
  - May choose a plan that includes prescription drug coverage
  - Benefits and cost-sharing may be different
  - May choose a plan that includes extra benefits such as vision or dental offered at the plan's expense (not covered by Medicare)



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

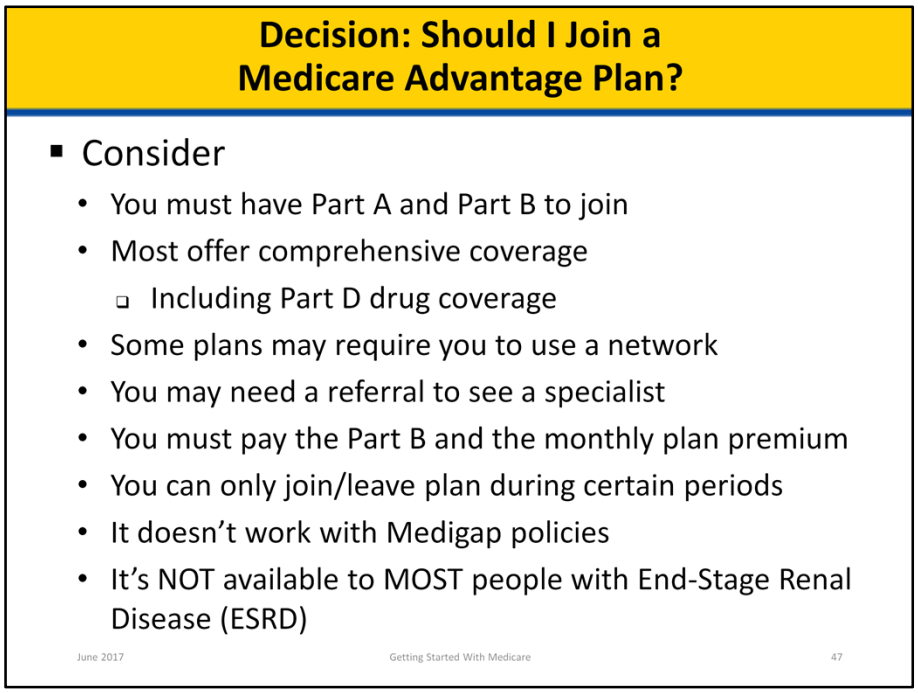
If you have Part A and enroll in Part B during the General Enrollment Period, you can join an MA Plan until June 30, so your MA coverage begins on July 1 along with your new Part B coverage.

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

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

If you belong to an MA Plan, you can disenroll to switch back to Original Medicare from January 1 through February 14 each year. If you go back to Original Medicare during this time, coverage under Original Medicare will take effect on the first day of the month following the date on which the election or change was made. If you make this change you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

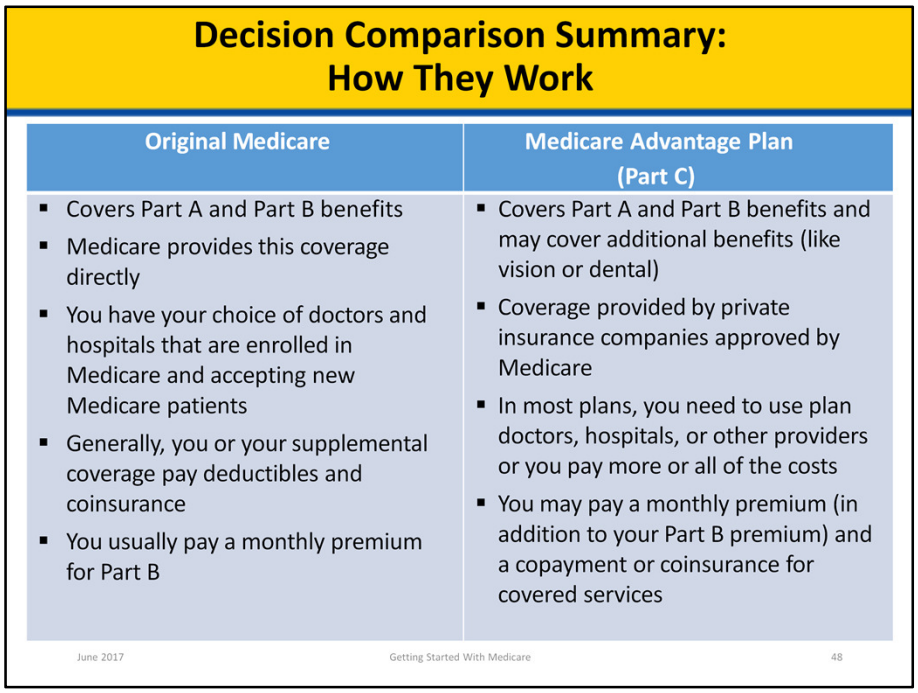
To find out which MA Plans are available in your area, visit Medicare.gov/find-a-plan to use the Medicare Plan Finder, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.



There are things to consider when deciding if you want to join a Medicare Advantage (MA) Plan:

- Must have Part A and Part B to join
- Most plans offer comprehensive coverage
- Including Part D drug coverage
- Some plans may require you to use a network
- You may need a referral to see a specialist
- You must pay Part B premium and monthly plan premium
- You can only join/leave plan during certain periods
- It doesn't work with Medigap policies

MA Plans are available to most people with Medicare. To be eligible to join an MA Plan, you must live in the plan's geographic service area or continuation area, have Medicare Part A and Part B, be a U.S. citizen or lawfully present in the United States and not have End-Stage Renal Disease (ESRD). People with ESRD usually can't join an MA Plan or other Medicare health plan. However, there are some exceptions.



This chart lets you compare Original Medicare and Medicare Advantage (MA) Plans side-by-side.

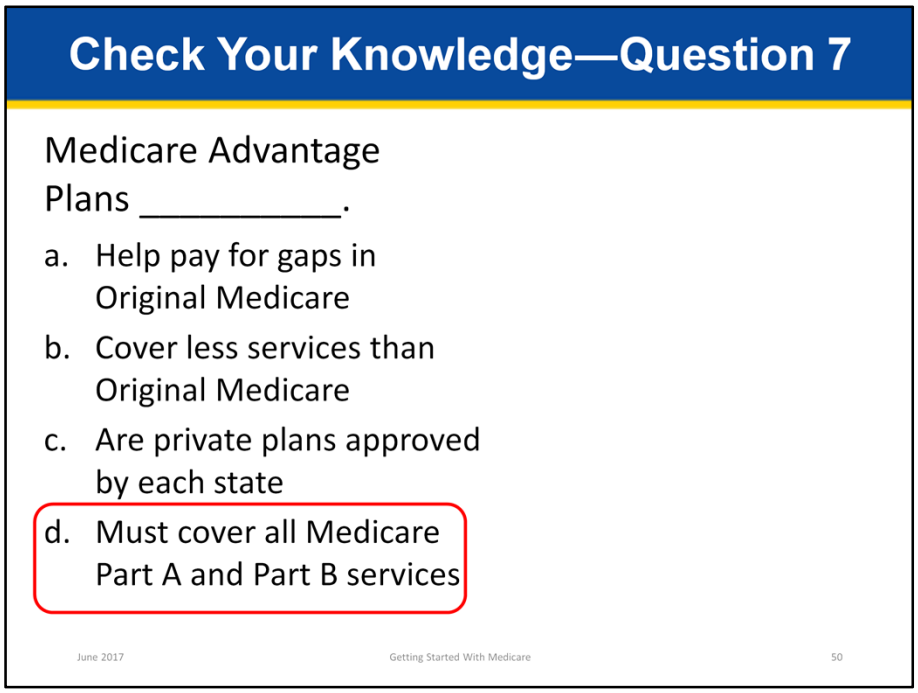
- Let's start with how Original Medicare works.
  - Covers Part A and Part B benefits
  - Medicare provides this coverage directly
  - You have your choice of doctors and hospitals that are enrolled in Medicare and accepting new Medicare patients
  - Generally, you or your supplemental coverage pays deductibles and coinsurance
  - You usually pay a monthly premium for Part B
- This is how MA works:
  - Covers Part A and Part B benefits and may cover additional benefits (like vision or dental)
  - Coverage provided by private insurance companies approved by Medicare
  - In most plans, you need to use doctors, hospitals, or other providers that are in the plan's network, or you may pay more or all of the costs
  - You may pay a monthly premium (in addition to your Part B premium) and a copayment or coinsurance for covered services

How Are Medigap Policies and Medicare Advantage Plans Different?

	Medicare Supplement (Medigap) Insurance) Policies	Medicare Advantage Plans (Part C)
Offered by	Private companies	Private companies
Government Oversight	State, but must also follow federal laws	Federal (plans must be approved by Medicare)
Works with	Original Medicare	N/A
Covers	Gaps in Original Medicare coverage, like deductibles, coinsurance, and copayments for Medicare-covered services.	All Part A and Part B covered services and supplies. May also cover things not covered by Original Medicare, like vision and dental coverage. Most MA plans include Medicare prescription drug coverage.
You must have	Part A and Part B	Part A and Part B
Do you pay a premium?	Yes. You pay a premium for the policy and you pay the Part B premium.	Yes. In most cases you pay a premium for the plan and you pay the Part B premium.

This chart displays a side-by-side comparison of Medicare Supplement Insurance (Medigap) Policies and Medicare Advantage (MA) Plans.

- Both are offered by private companies.
- Government Oversight—Medigap must follow federal and state laws, but routine day-to-day oversight of Standardized Medigap policies are under the purview of the states. MA Plans must be approved by Medicare.
- Medigap only works with Original Medicare. MA Plans **don't** work with Medigap policies. If you join an MA Plan, you can't use a Medigap policy to pay for out-of-pocket costs you have in the MA Plan.
- Original Medicare pays for many, but not all, health care services and supplies. Private insurance companies sell Medigap policies to help pay for some of the out-of-pocket costs ("gaps") that Original Medicare doesn't cover. Medigap policies don't pay your Medicare premiums. Most Medigap policies don't cover out-of-pocket drug expenses, and you would need to consider a Part D plan. Some older policies (no longer sold) may have included some drug expense coverage (Plan I). MA Plans cover Part A and Part B covered services, may include Part D and may cover certain non-covered benefits such as vision and dental.
- In both cases, you must have Part A **and** Part B to join.
- You pay a premium for a Medigap policy or an MA Plan, and you pay the Part B premium.
- If you already have an MA Plan, it's illegal for anyone to sell you a Medigap policy unless you're disenrolling from your MA Plan to go back to Original Medicare.

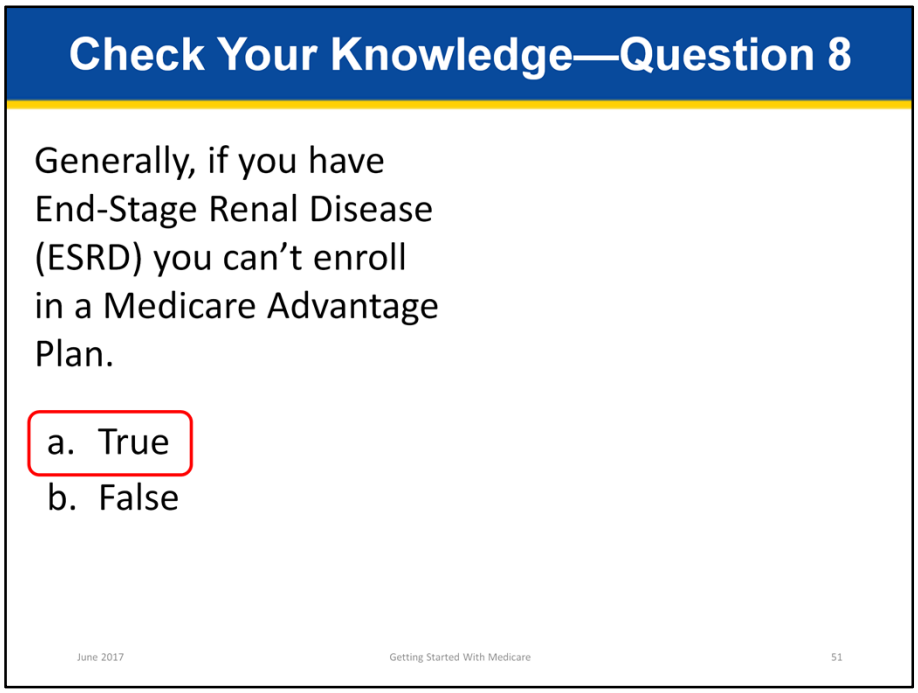


Check Your Knowledge—Question 7

Medicare Advantage plans _____.

a. Help pay for gaps in Original Medicare
b. Cover less services than Original Medicare
c. Are private plans approved by each state
d. Must cover all Medicare Part A and Part B services

Answer: d. Must cover all Medicare Part A and Part B services. They offer all Part A and Part B covered services, but may cover additional benefits not covered by Original Medicare, like vision and dental. Their cost-sharing may be different than that of Original Medicare. They are run by private companies, but they must be approved by Medicare.



Check Your Knowledge—Question 8

Generally, if you have End-Stage Renal Disease (ESRD) you can't enroll in a Medicare Advantage Plan.

a. True

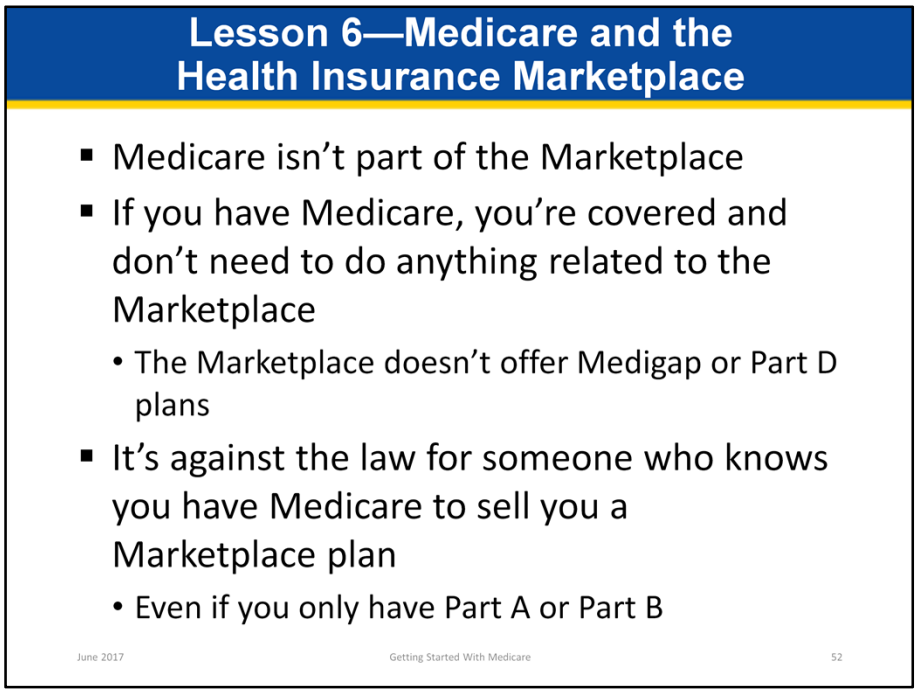
b. False

Answer: a. True

If you have ESRD, you'll usually get your health care through Original Medicare.

You can only join an MA Plan (Part C) in certain situations:

- If you're already in an MA Plan when you develop ESRD, you may be able to stay in your plan or join another plan offered by the same company.
- If you're already getting your health benefits (for example, through an employer health plan) through the same organization that offers the MA Plan.
- If you had ESRD, but have had a successful kidney transplant, and you still qualify for Medicare benefits (based on your age or a disability), you can stay in Original Medicare, or join an MA Plan.
- You may be able to join a Medicare Special Needs Plan for people with ESRD if one is available in your area.



Medicare isn't a part of the Health Insurance Marketplace. If you have Medicare Part A only, you're considered to have minimum essential coverage (coverage that you need to have to meet the individual responsibility requirement under the Affordable Care Act). If you have both Medicare Part A and Part B, you're also considered covered. You wouldn't need a Qualified Health Plan (QHP) in the Marketplace. If you have Part A, you don't have to do anything related to the Marketplace. The Marketplace doesn't change your Medicare plan choices or your benefits.

No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like an Health Maintenance Organization or Preferred Provider Organization), you won't have to make any changes. The Marketplace doesn't offer Medicare Supplement Insurance (Medigap) policies or Medicare Part D plans.

It's against the law for someone who knows that you have Medicare to sell you a Marketplace plan. This is true even if you have only Part A or only Part B.

If you have **only** Medicare Part B, you aren't considered to have minimum essential coverage.

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. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like a Health Maintenance Organization or a Preferred Provider Organization), you need to return to the Marketplace and end any subsidies, such as Advanced Premium Tax Credits or cost sharing reductions, which are being paid on your behalf. 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.

Reference:

- HealthCare.gov/medicare/changing-from-marketplace-to-medicare/

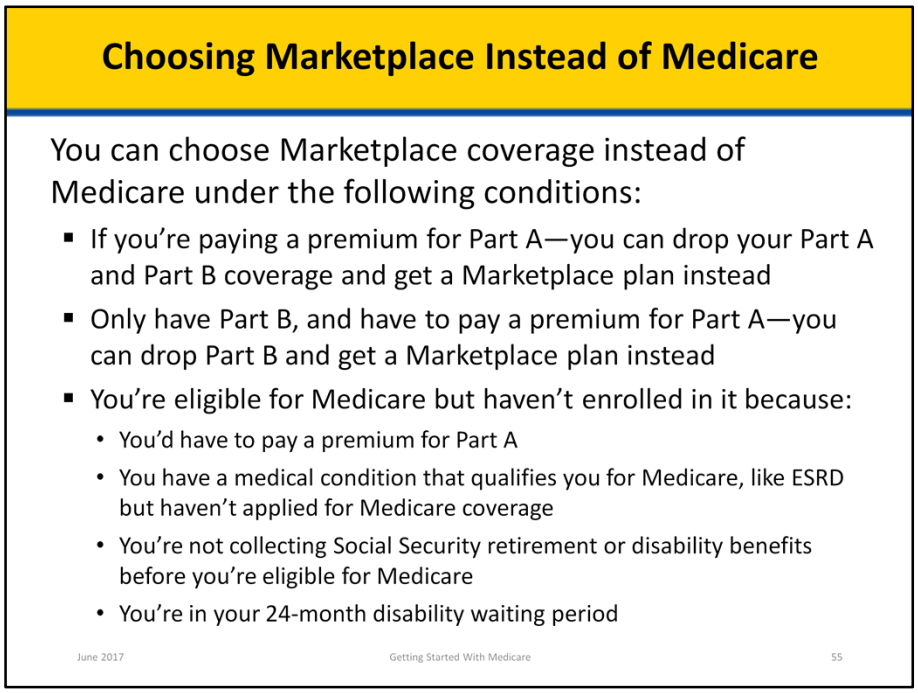
If you're entitled to Social Security Disability Insurance (SSDI), you may qualify for Medicare. There is a 24-month waiting period before Medicare coverage can start. During this waiting period, you can apply for coverage in the Marketplace. You can find out if you'll qualify for Medicaid or for premium 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 25th month of disability benefits. If you don't want Part B, follow the instructions that are included with the card.

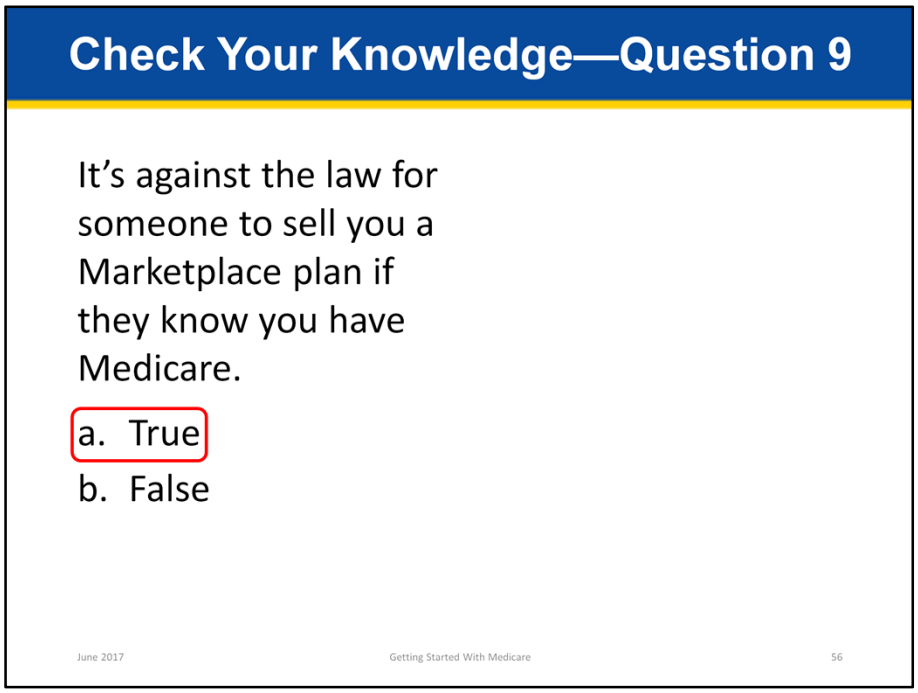
Once you're eligible for Medicare, you won't be able to get lower costs for a Marketplace plan based on your income. Once your Part A coverage starts, any premium tax credits and reduced cost-sharing you may have qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

Also, remember, the Qualified Health Plan isn't required to pay any costs toward your coverage once you have Medicare.



You can choose Marketplace coverage instead of Medicare under the following conditions:

- If you're paying a premium for Part A—you can drop your Part A and Part B coverage and get a Marketplace plan instead
- Only having Part B, and have to pay a premium for Part A—you can drop Part B and get a Marketplace plan instead
- If you're eligible for Medicare but haven't enrolled in because:
  - You'd have to pay a premium for Part A
  - You 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 collecting Social Security retirement or disability benefits before you're eligible for Medicare
  - You're in your 24-month disability waiting period



Check Your Knowledge—Question 9

It's against the law for someone to sell you a Marketplace plan if they know you have Medicare.

a. True

b. False

Answer: a. True

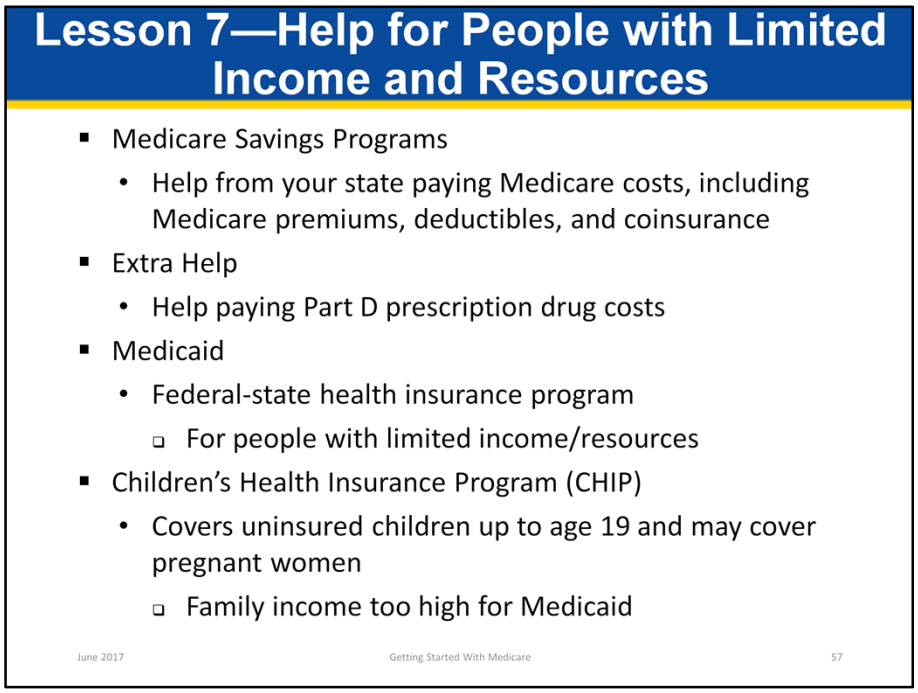
It's against the law for someone to sell you a Marketplace plan if they know you have Medicare. You can choose Marketplace coverage instead of Medicare if you

- Would have to pay a premium for Part A, and haven't enrolled in Medicare.
- Have a medical condition that qualifies you for Medicare, like End-Stage Renal Disease, but haven't applied for Medicare coverage.
- Are in the 24-month waiting period for Medicare entitlement due to a disability.
- Aren't yet collecting Social Security retirement or disability benefits before you're eligible for Medicare.

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 Part B 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.
3. If you're eligible for premium free Part A, you won't be eligible for any Advanced Premium Tax Credits or cost sharing reductions. 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.

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.



There are programs available to help people with limited income and resources pay their health care and/or prescription drug costs. These include Medicare Savings Programs, Extra Help, Medicaid, and the Children's Health Insurance Program (CHIP). You should apply for these programs if you have limited income and resources. Even if you're not sure you qualify, you should apply. Visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Medicare Savings Program: This program provides help from your state paying Medicare costs, including Medicare premiums, deductibles, and coinsurance; it often has higher income and resource guidelines than full Medicaid. Visit Medicare.gov/contacts/#resources/msps to see your state's program.

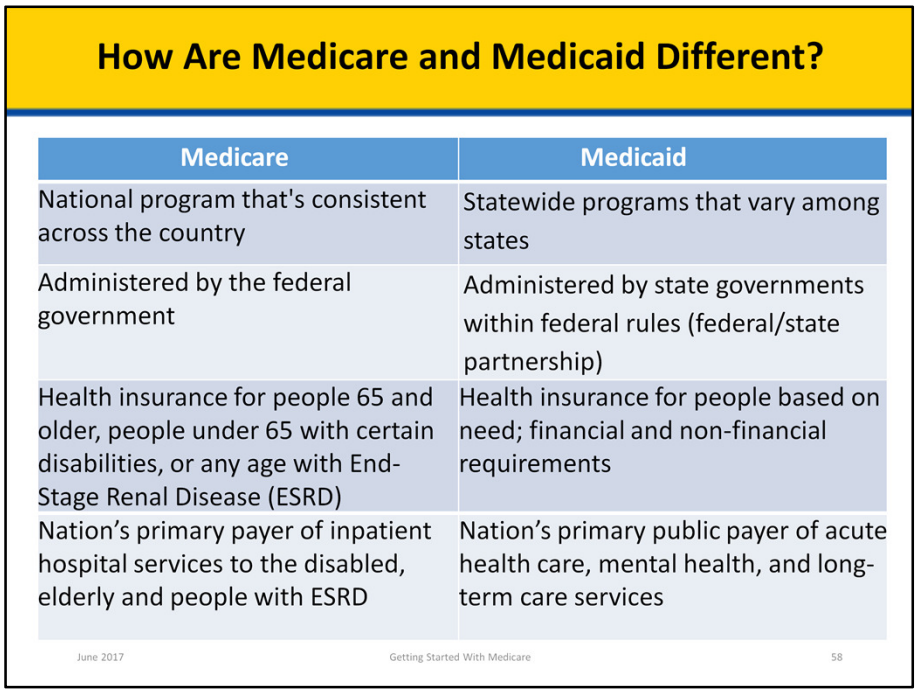
Extra Help: This program helps people with limited income and resources with the costs of Medicare prescription drug coverage. It is also called low-income subsidy. Some people with Medicare must apply for Extra Help. You can apply by filling out a paper application, applying at socialsecurity.gov, or contacting your state Medical Assistance office.

Medicaid: This program helps pay medical costs for some people with limited income and resources; it's jointly funded by the federal and state governments and is administered by each state.

CHIP: This program provides low-cost health insurance to children in families who earn too much income to qualify for Medicaid, but not enough to buy private health insurance.

Federal Poverty Levels income limits are usually updated each February for the same calendar year and can be accessed at aspe.hhs.gov/poverty-guidelines.

For more information visit Medicaid.gov/medicaid-chip-program-information/by-population/medicare-medicaid-enrollees-dual-eligibles/seniors-and-medicare-and-medicaid-enrollees.html or call or visit your state Medical Assistance office.



Medicare and Medicaid are different in the following ways:

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

2017 Medicare Savings Program Income/Resource Limits

Medicare Savings Program	Individual Monthly Income Limit*	Married Couple Monthly Income Limit*	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,025	$1,374	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,226	$1,644	Part B premiums only
Qualifying Individual (QI)	$1,377	$1,847	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	$4,105	$5,499	Part A premiums only

*Visit your state's MSP Website

June 2017 Getting Started With Medicare 59

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

NOTE: Federal law bars Medicare and MA providers from balance billing a QMB beneficiary under any circumstances.

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

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

If you qualify for the Qualified Disabled and Working Individual (QDWI) you get help paying your Part A premium. To qualify, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding substantial gainful activity (SGA); have an income not higher than 200% of the FPL resources not exceeding twice the maximum for Supplemental Security Income ($4,000 for an individual and $6,000 for married couple in 2017); and not be otherwise eligible for Medicaid. If you qualify, you get help paying your Part A premium. If your income is between 150% and 200% of the FPL, the state can ask you to pay a part of the Medicare Part A premium. The asset limits are $4,000 (individual) and $6,000 (married couple).

In 2017, the asset limits for the QMB, SLMB, and QI Programs are $7,390 for a single person and $11,090 for a married person living with a spouse and no other dependents. *These resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index since September of the previous year, official in April of each year.

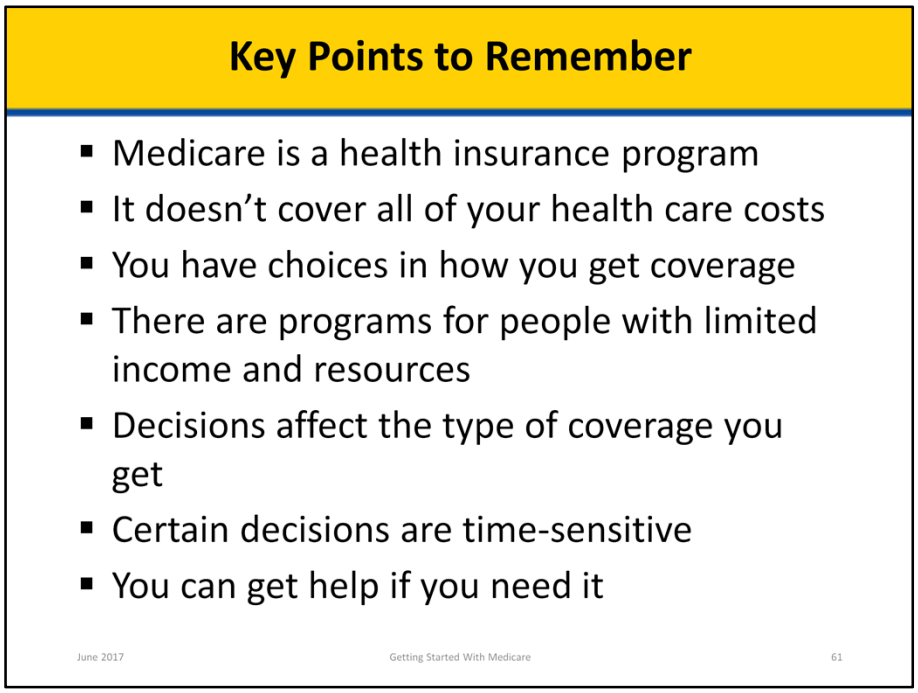
See also Medicare.gov/contacts/#resources/msps to access your state's Medicare Savings Program website.

NOTE: The Medicare Savings Program Income/Resource Limits information is typically released in January/February each year.

There are a variety of resources available to help you learn more and answer any questions, including:

- Medicare website—you can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. Medicare.gov
- Medicaid website Medicaid.gov
- Social Security website—you can call your local SSA office socialsecurity.gov
- Health Insurance Marketplace website HealthCare.gov
- Children's Health Insurance Program website InsureKidsNow.gov
- CMS National Training Program CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html
- State Health Insurance Assistance Program (SHIPs)—you can call your local SHIP office Medicare.gov/contacts/organization-search-criteria.aspx

NOTE: A complete list is available at Web Resources Job Aid



Here are some key points to remember:

- Medicare is a health insurance program.
- It doesn't cover all of your health care costs.
- You have choices in how you get your coverage.
- There are programs for people with limited income and resources.
- You have choices to make. It's important to know when you need to take action. Your decisions affect the type of coverage you get. Certain decisions are time-sensitive.
- There is help available if you need it.

NOTE: For a more detailed review of information contained in this module, please refer to the training module "Understanding Medicare" and other topic-specific modules, visit CMS.gov/Outreach-and-Education/Training/ CMSNationalTrainingProgram/Training-Library.html.

Acronyms

ALS Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)

CHAMPVA Civilian Health and Medical Program of the Department of Veterans Affairs

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

EGHP Employer Group Health Plan

ESRD End-Stage Renal Disease

FICA Federal Insurance Contributions Act

FPL Federal Poverty Level

GEP General Enrollment Period

HMO Health Maintenance Organization

HSA Health Savings Account

IEP Initial Enrollment Period

IRMAA Income-Related Monthly Adjustment Amount

IRS Internal Revenue Service

MA Medicare Advantage

MA-PD Medicare Advantage Prescription Drug

MEC Minimal Essential Coverage

MSA Medical Savings Account

NTP National Training Program

Acronyms (continued)

OEP Open Enrollment Period

PACE Programs of All-Inclusive Care for the Elderly

PDP Prescription Drug Plan

PFFS Private Fee-for-Service

POS Point of Service

PPO Preferred Provider Organization

QHP Qualified Health Plan

QI Qualified Individual

QMB Qualified Medicare Beneficiary

RRB Railroad Retirement Board

SEP Special Enrollment Period

SHIP State Health Insurance Assistance Program

SLMB Specified Low-income Medicare Beneficiary

SNF Skilled Nursing Facility

SNP Special Needs Plans

SSA Social Security Administration

SSDI Social Security Disability Insurance

TFL TRICARE for Life

TTY Teletypewriter/Text Telephone

VA U.S. Department of Veterans Affairs

VSMI Variable Supplementary Medical Insurance

This training is provided by the CMS National Training Program (NTP).

To view all available NTP materials, or to subscribe to our email list, visit CMS.gov/outreach-and-education/training/CMSNationalTrainingProgram.

Contact us at training@cms.hhs.gov.

Follow us @CMSGov #CMSNTP.