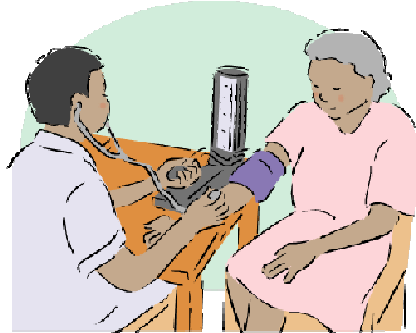


Medicare 2011



Course Manual
6 credit hours
Online Non-Interactive



Important Information

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Acknowledgement

The information presented in this course was obtained from the following websites:

<http://www.cms.gov>

<http://www.medicare.gov>

<http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

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Medicare History

On July 30, 1965, President Lyndon B. Johnson signed into law the Social Security Amendments of 1965 which established Medicare. The signing ceremony occurred in Independence, Missouri at the Truman Library with former President Harry Truman seated beside President Johnson. The ceremony was held at the Truman Library to honor President Truman's leadership on health insurance, which he first proposed in 1945.

President Johnson's speech that day summarized the original purpose and scope of Medicare. Here is an excerpt from that speech:

"There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

And through this new law, Mr. President (Truman), every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will help meet the fees of the doctors.

Now here is how the plan will affect you.

During your working years, the people of America--you--will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about \$1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing home after a period of hospital care.

And under a separate plan, when you are 65--that the Congress originated itself, in its own good judgment-- you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount.

The benefits under the law are as varied and broad as the marvelous modern medicine itself. If it has a few defects--such as the method of payment of certain specialists - then I am confident those can be quickly remedied and I hope they will be.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

Since 1965, a number of changes have been made to Medicare. Below are some of the key legislative milestones that have shaped Medicare and other related programs.

1965—Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about half had insurance coverage.

1966—Medicare was implemented and more than 19 million individuals enrolled on July 1.

1967—An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.

1972—Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs. Medicaid eligibility for elderly, blind and disabled residents of a state could be linked to eligibility for the newly enacted Federal Supplemental Security Income program (SSI).

1973—The HMO Act provided for start-up grants and loans for the development of health maintenance organizations (HMOs); HMOs meeting Federal standards relating to comprehensive benefits and quality were given preferential treatment in the marketplace.

1977—The Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs.

1980—Coverage of Medicare home health services was broadened. Medicare supplemental insurance, also called "Medigap," was brought under Federal oversight.

1981—Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid; states were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., DSH hospitals).

1982—The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program. In addition, the Act expanded the Agency's quality oversight efforts through Peer Review Organizations (PROs).

1983—An inpatient acute hospital prospective payment system for the Medicare program, based on patients' diagnoses, was adopted to replace cost-based payments.

1985—The Emergency Medical Treatment and Labor Act (EMTALA) required hospitals participating in Medicare that operated active emergency rooms to provide appropriate medical screenings and stabilizing treatments.

1986—Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the Federal Poverty Level (FPL) was established as a state option.

1987—The Omnibus Budget Reconciliation Act of 1987 (OBRA87) strengthened the protections for residents of nursing homes.

1988—The Medicare Catastrophic Coverage Act, which included the most significant changes since enactment of the Medicare program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability; Medicaid coverage for pregnant women and infants to 100 percent FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent "spousal impoverishment"; Qualified Medicare Beneficiary (QMBs) program was established to pay Medicare premiums and cost sharing charges for beneficiaries with incomes and resources below established thresholds; the Clinical Laboratory Improvement Amendments (CLIA) strengthened quality performance requirements for clinical laboratories in order to assure accurate and reliable laboratory tests and procedures.

1989—The Medicare Catastrophic Coverage Act of 1988 was repealed after higher-income elderly protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments. Limits were placed on physician balance billing above the new fee schedule. Physicians were prohibited from referring Medicare patients to clinical laboratories in which their physicians, or physicians' family members, have a financial interest. Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL was mandated; expanded EPSDT requirements were established.

1990—Phased in Medicaid coverage of children ages 6 through 18 under 100 percent FPL was established; Medicaid prescription drug rebate program was established; Specified Low-Income Medicare beneficiary eligibility group was established (SLMBs) for Medicaid programs to pay Medicare premiums for beneficiaries with incomes at least 100 percent but not more than 120 percent of the FPL and limited financial resources; additional federal standards for Medicare supplemental insurance were enacted.

1991—Medicaid Disproportionate Share Hospital (DSH) spending controls were established and provider-specific taxes and donations to states were capped.

1996—Welfare Reform - The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant; the welfare link to Medicaid was severed; a new mandatory low income group not linked to welfare was added; and enrollment / termination of Medicaid was no longer automatic with receipt/loss of welfare cash assistance. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) had several provisions. First, it amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for new Federal rules improving continuity or "portability" of coverage in the large group, small group and individual health insurance markets. CMS implements HIPAA provisions affecting the small group and individual markets. Second, it created the Medicare Integrity Program which dedicated funding to program integrity activities and allowed CMS to competitively contract for program integrity work. Third, it created national administrative simplification standards for electronic health care transactions. Fourth, it required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.

1997—Balanced Budget Act of 1997 (BBA) - State Children's Health Insurance Program (SCHIP) was created; limits on Medicaid payments to disproportionate share hospitals were revised; new Medicaid managed care options and requirements for states were established. Medicare changes include: establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process; expanding education and information to help beneficiaries make informed choices about their health care; requiring CMS to develop and implement five new prospective payment systems for Medicare services (for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services); slowing the rate of growth in Medicare spending and extending the life of the trust fund for 10 years; providing a broad range of beneficiary protections; expanding preventive benefits; and testing other innovative approaches to payment and service delivery through research and demonstrations.

1998—The internet site www.medicare.gov was launched to provide updated information about Medicare.

1999—The toll-free number, 1-800-MEDICARE (1-800-633-4227), was available nationwide. The first annual Medicare & You handbook was mailed to all Medicare beneficiary households. The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. Established optional Medicaid eligibility groups and allowed states to offer a buy-in to Medicaid for working-age individuals with disabilities. The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and increased the amount of Medicaid DSH funds available to hospitals in certain States and the District of Columbia. Other related legislation improved Medicaid coverage of certain women's health services.

2000—The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary copayments, and improved Medicare's coverage of preventive services; BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics and it modified the amount of Medicaid DSH funds available to hospitals, while it provided a one year extension on the sunset of transitional medical assistance provided to families eligible for welfare.

2003—The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made the most significant changes to Medicare since the program began. MMA creates a prescription drug discount card until 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. In 2006, the new voluntary Part D outpatient prescription drug benefit will be available to beneficiaries from private drug plans as well as Medicare Advantage plans. Employers who provide retiree drug coverage comparable to Medicare's will be eligible for a federal subsidy. Medicare will consider beneficiary income for the first time: beneficiaries with incomes less than 150% of the federal poverty limit will be eligible for subsidies for the new Part D prescription drug program; beneficiaries with higher incomes will pay a greater share of the Part B premium starting in 2007.

Medicare Basics

Medicare is the national health insurance program for:

- People age 65 or older
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant

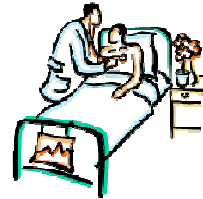
Medicare is administered by Centers for Medicare & Medicaid Services (CMS), which is a Federal agency within Department of Health and Human Services (HHS). According to the U.S. Census Bureau, approximately 46 million Americans were enrolled in Medicare in 2009.



Medicare Parts

Part A – Hospital Insurance

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care



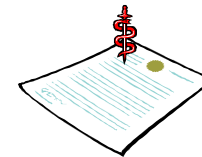
Part B – Medical Insurance

- Helps cover doctors' services, hospital outpatient care, and home health care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse



Part C – Advantage Plans

- Offered by private companies approved by Medicare
- Provides all of your Part A (Hospital Insurance), Part B (Medical Insurance), and may cover additional services



Part D – Medicare Prescription Drug Coverage

- A prescription drug option run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

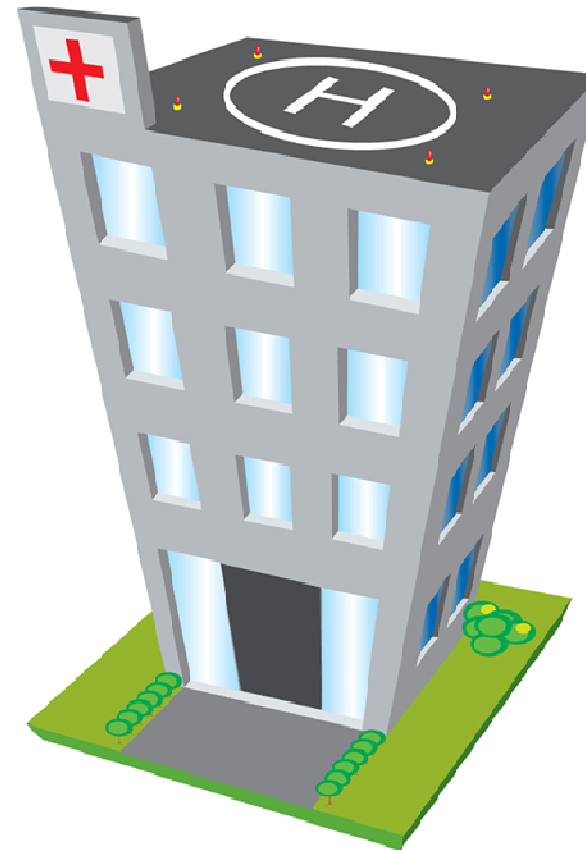


Part A — Covered Expenses

Medicare Part A is also known as “hospital” insurance. It helps pay expenses for the following services:

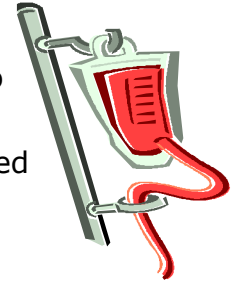
- Inpatient care in hospitals
- Inpatient care in a skilled nursing facility (not custodial or long term care)
- Hospice care services
- Home health care services
- Inpatient care in a Religious Nonmedical Health Care Institution

The following slides provide more details about expenses covered by Part A.



Part A — Blood

In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.



Part A — Home Health Services

This is limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.



Part A — Hospice Care

This is for people with a terminal illness. Your doctor must certify that you're expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, social services; certain durable medical equipment and other covered services as services Medicare usually doesn't cover, such as spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live like a nursing home.

Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility which contracts with the hospice. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.



Part A — Inpatient Hospital Stays

Includes semi-private room, meals, general nursing, drugs as part of your inpatient treatment, and other hospital services and supplies. Examples include inpatient care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care.

This doesn't include private-duty nursing, a television or telephone in your room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it covers the doctor's services you get while you're in a hospital.

Part A — Religious Nonmedical Health Care Institution

Medicare will only cover the non-medical, non-religious health care items and services (like room and board) in this type of facility for people who qualify for hospital or skilled nursing facility care, but for whom medical care isn't in agreement with their religious beliefs. Non-medical items and services like wound dressings or use of a simple walker during your stay don't require a doctor's order or prescription. Medicare doesn't cover the religious aspects of care.

Part A — Skilled Nursing Facility Care

Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a 3-day minimum inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare doesn't cover long-term care or custodial care.



Part B — Medically-Necessary Services

Medicare Part B is also known as “Medical” insurance. It helps pay for medically-necessary services, which are defined as:

- Services or supplies that are needed for the diagnosis or treatment of your medical condition, and
- Meet accepted standards of medical practice.

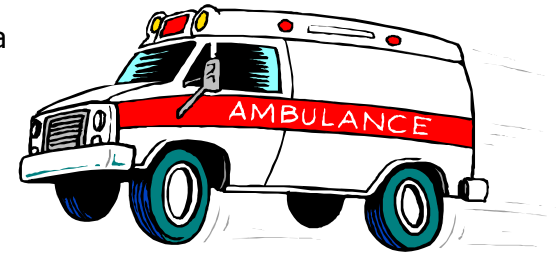
Examples include doctors’ services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

The following slides list of some of these services that are covered by Part B. For a complete list, visit <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.



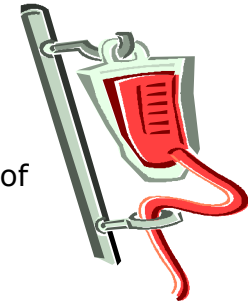
Part B — Ambulance Services

Ground ambulance transportation when you need to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.



Part B — Blood

In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.



Part B — Clinical Laboratory Services

This includes certain blood tests, urinalysis, some screening tests, and more.

Part B — Diabetes Supplies

This includes blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin is covered only if used with an external insulin pump.



Part B — Doctor Services

Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services.

Part B — Durable Medical Equipment

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



Part B — Emergency Department Services

This is when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies.

Part B — Home Health Services

This covers medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it.

Part B — Mental Health Care (outpatient)

This is to get help with mental health conditions such as depression or anxiety. This includes services generally given outside a hospital or in a hospital outpatient setting, including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, or clinical social worker; substance abuse services; and lab tests. Certain limits and conditions apply.



Part B — Non-doctor Services

Medicare covers services provided by certain non-doctors, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists.

Part B — Occupational Therapy

Evaluation and treatment to help you return to usual activities (such as dressing or bathing) after an illness or accident when your doctor certifies you need it. There may be limits on these services and exceptions to these limits.

Part B — Outpatient Medical & Surgical Services & Supplies

For approved procedures (like X-rays, a cast, or stitches).



Part B — Physical Therapy

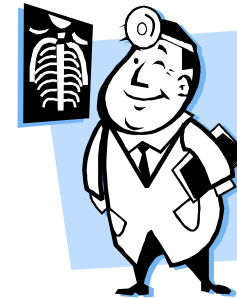
This is evaluation and treatment for injuries and diseases that change your ability to function when your doctor certifies your need for it. There may be limits on these services and exceptions to these limits.

Part B — Prosthetic/Orthotic Items

Includes arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when your doctor orders it. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that is enrolled in Medicare.

Part B — Tests (other than lab tests)

This includes X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests.



Part B — Transplants & Immunosuppressive Drugs

This includes doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare covers bone marrow and cornea transplants under certain conditions. Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have been entitled to Part A at the time of the transplant, and you must be entitled to Part B at the time you get immunosuppressive drugs.

Part B — Travel

Medicare generally doesn't cover health care while you're traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions that are allowed.



Part B — Urgently-Needed Care

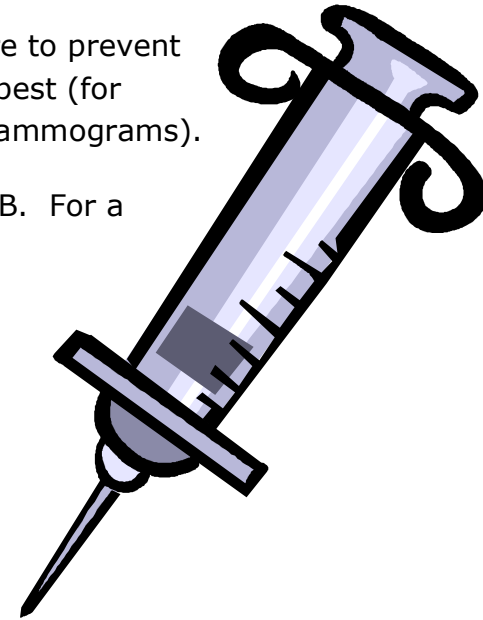
To treat a sudden illness or injury that isn't a medical emergency.



Part B — Preventive Services

Medicare Part B also covers some **preventive services**. This is health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

The following slides list of some of these services that are covered by Part B. For a complete list, visit <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.



Part B — Abdominal Aortic Aneurysm Screening

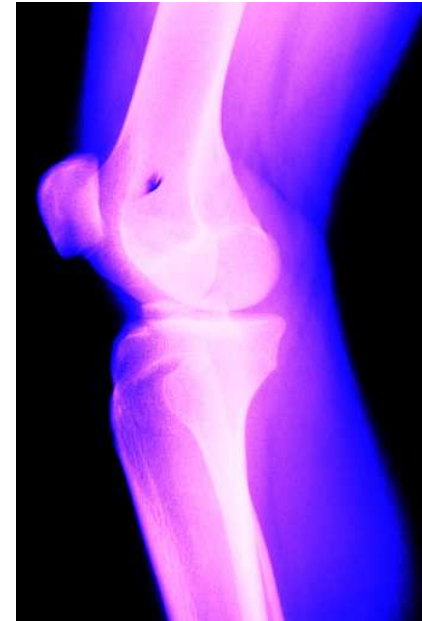
This is a one-time screening ultrasound for people at risk. You must get a referral for it as part of your one-time “Welcome to Medicare” physical exam.

Part B — Bone Mass Measurement (Bone Density)

This helps to see if you’re at risk for broken bones. This service is covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor accepts assignment.

Part B — Cardiovascular Screenings

Blood tests that help detect conditions that may lead to a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. You pay nothing for the tests, but you generally have to pay 20% of the Medicare-approved amount for the doctor’s visit.



Part B — Colorectal Cancer Screenings

To help find precancerous growths or find cancer early, when treatment is most effective. Types of tests that may be covered include:

- Fecal occult blood test,
- Flexible sigmoidoscopy,
- Colonoscopy,
- Barium enema.



Part B — Diabetes Screenings

Medicare covers these screenings if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every year.

Part B — Diabetes Self-Management Training

This is for people with diabetes with a written order from a doctor or other health care provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

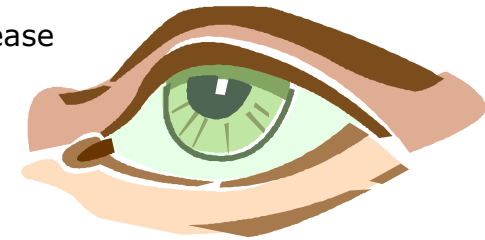


Part B — Flu Shots

This is generally covered once per flu season in the fall or winter. You pay nothing for the flu shot if the doctor or other health care provider accepts assignment for giving the shot. You pay nothing if your doctor accepts assignment for giving the shot.

Part B — Glaucoma Tests

This is covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older. An eye doctor who is legally allowed by the state must do the tests.



Part B — Hepatitis B Shots

This is covered for people at high or medium risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End Stage Renal Disease (ESRD), or certain conditions that increase your risk for infection. Other factors may increase your risk for Hepatitis B, so check with your doctor. You pay nothing for the shot if the doctor accepts assignment.

Part B — HIV Screening

Medicare covers HIV (Human Immunodeficiency Virus) screening for people with Medicare of any age who ask for the test, pregnant women, and people at increased risk for the infection. Medicare covers this test once every 12 months or up to 3 times during a pregnancy.

Part B — Mammograms (screening)

This is a type of X-ray to check women for breast cancer. Medicare covers screening mammograms once every 12 months for women 40 and older. Medicare covers one baseline mammogram for women between 35–39. You pay nothing for the test if the doctor accepts assignment.

Part B — Medical Nutrition Therapy Services

Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor refers you for the service. You pay nothing for these services if the doctor accepts assignment.



Part B — Pap Tests and Pelvic Exams (includes clinical breast exam)

Checks for cervical, vaginal, and breast cancers. Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women who have Medicare and are of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years. You pay nothing for the Pap lab test, Pap test specimen collection, and pelvic and breast exams if the doctor accepts assignment.

Part B — Physical Exams

Medicare covers two types of physical exams—one when you're new to Medicare and one each year after that.

"Welcome to Medicare" physical exam — A one-time review of your health, education and counseling about preventive services, and referrals for other care if needed. Medicare will cover this exam if you get it within the first 12 months you have Part B. You pay nothing for the exam if the doctor accepts assignment. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" physical exam. Keep in mind, you don't need to get the "Welcome to Medicare" physical exam before getting a yearly "Wellness" exam.



Yearly **"Wellness"** exam — If you've had Part B for longer than 12 months, you can get a yearly wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. You pay nothing for this exam if the doctor accepts assignment. This exam is covered once every 12 months.

Note: Your first yearly "Wellness" exam can't take place within 12 months of your "Welcome to Medicare" physical exam.

Part B — Pneumococcal Shot

Helps prevent pneumococcal infections (like certain types of pneumonia). Most people only need this shot once in their lifetime. Talk with your doctor. You pay nothing if the doctor or supplier accepts assignment for giving the shot.

Part B — Prostate Cancer Screenings

Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for men over 50 (coverage for this test begins the day after your 50th birthday). You pay nothing for the PSA test.

Part B — Smoking Cessation

Medicare coverage of smoking cessation counseling is now considered a covered preventive service if you haven't been diagnosed with an illness caused or complicated by tobacco use.



Not Covered by Parts A & B

Some of the items and services that Medicare doesn't cover include the following:

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Exams for fitting hearing aids



Some People Automatically Get Parts A & B

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

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

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

Some People Must Sign Up for Parts A & B

If you aren't getting Social Security or RRB benefits (for instance, because you're still working) and you want Part A or Part B, you will need to sign up (even if you're eligible to get Part A premium-free). If you're not eligible for premium-free Part A, you can buy Part A and Part B. You should contact Social Security 3 months before you turn 65. If you worked for a railroad, contact the RRB to sign up.

If you have End-Stage Renal Disease (ESRD), you should visit your local Social Security office, or call Social Security at 1-800-772-1213 to sign up for Part A and Part B.

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility, and to sign up for Part A and/or Part B. If you're 65 or older, you can also apply for premium-free Part A and Part B online at www.socialsecurity.gov/retirement. The whole process can take less than 10 minutes.

Parts A & B — Initial Enrollment Period

You can sign up when you're first eligible for Part B. This is known as the **Initial Enrollment Period**. (For example, if you're eligible for Part B when you turn 65, this is a 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.)

If you enroll in Part B during the first three months of your Initial Enrollment Period, your coverage start date will depend on your birthday.

If your birthday isn't on the first day of the month, your Part B coverage starts the first day of your birthday month. For example, Mr. Green's 65th birthday is July 20, 2011. If he enrolls in April, May, or June, his coverage will start on July 1, 2011.

If your birthday is on the first day of the month, your coverage will start the first day of the prior month. For example, Mr. Kim's 65th birthday is July 1, 2011. If he enrolls in March, April, or May, his coverage will start on June 1, 2011.

If you enroll in Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your Part B start date will be delayed. The more months you wait to enroll, the more delay there will be for coverage to start.



Parts A & B — General Enrollment Period

If you didn't sign up for Part A and/or Part B (for which you pay monthly premiums) when you were first eligible, you can sign up between January 1–March 31 each year. This is known as the **General Enrollment Period**. Your coverage will begin July 1. You may have to pay a higher premium for late enrollment.

Parts A & B — Special Enrollment Period

If you didn't sign up for Part A and/or Part B (for which you pay monthly premiums) when you were first eligible because you're covered under a group health plan based on current employment, you can sign up for Part A and/or Part B as follows:

- Anytime that you or your spouse (or family member if you're disabled) are working, and you're covered by a group health plan through the employer or union based on that work; or
- During the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.

Usually, you don't pay a late enrollment penalty if you sign up during this **Special Enrollment Period**. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD). You may also qualify for a Special Enrollment Period if you're a volunteer serving in a foreign country.

Part A — Monthly Premium

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

If you aren't eligible for premium-free Part A, you may be able to buy Part A if you meet one of the following conditions:

- You're 65 or older, and you're entitled to (or enrolling in) Part B and meet the citizenship and residency requirements.
- You're under 65, disabled, and your premium-free Part A coverage ended because you returned to work. (If you're under 65 and disabled, you can continue to get premium-free Part A for up to 8.5 years after you return to work.)



Note: The 2011 monthly premium amount for people who have to pay for Part A varies (up to \$450).

In most cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both. 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 users should call 1-800-325-0778.

Part A — Late Enrollment Penalty

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 will have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign-up. For example, if you were eligible for Part A for 2 years but didn't sign-up, you will have to pay the higher premium for 4 years. Usually, you don't have to pay a penalty if you meet certain conditions that allow you to sign up for Part A during a Special Enrollment Period.

Part B — Monthly Premium

You pay the Part B premium each month. Most people will pay the standard premium amount (\$115.40 in 2011). However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided by the IRS) is above a certain amount, you may pay more.

If Your Yearly Income in 2009 was		
File Individual Tax Return	File Joint Tax Return	You Pay
\$85,000 or below	\$170,000 or below	\$115.40
\$85,001-\$107,000	\$170,001-\$214,000	\$161.50
\$107,001-\$160,000	\$214,001-\$320,000	\$230.70
\$160,001-\$214,000	\$320,001-\$428,000	\$299.90
above \$214,000	above \$428,000	\$369.10

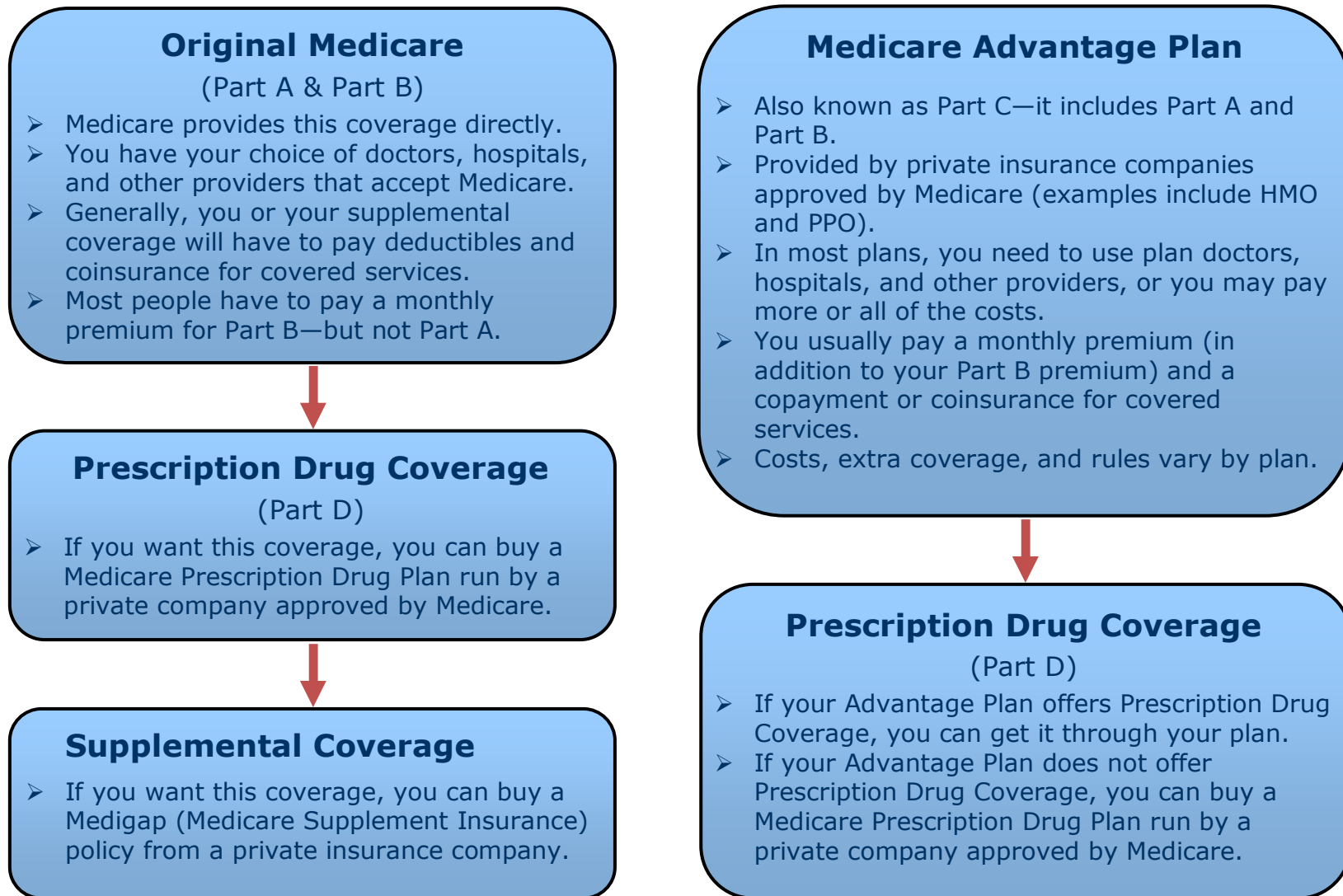
Your modified adjusted gross income is your adjusted gross income plus your tax exempt interest income. Each year, Social Security will notify you if you have to pay more than the standard premium. Whether you pay the standard premium or a higher premium can change each year depending on your income. If you have to pay a higher amount for your Part B premium and you disagree (even if you get RRB benefits), call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Part B — Late Enrollment Penalty

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 Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Usually, you don't pay a late enrollment penalty if you meet certain conditions that allow you to sign up for Part B during a special enrollment period.

Medicare Choices

There are two main ways to get Medicare coverage: You can choose either **Original Medicare** or a **Medicare Advantage Plan**.

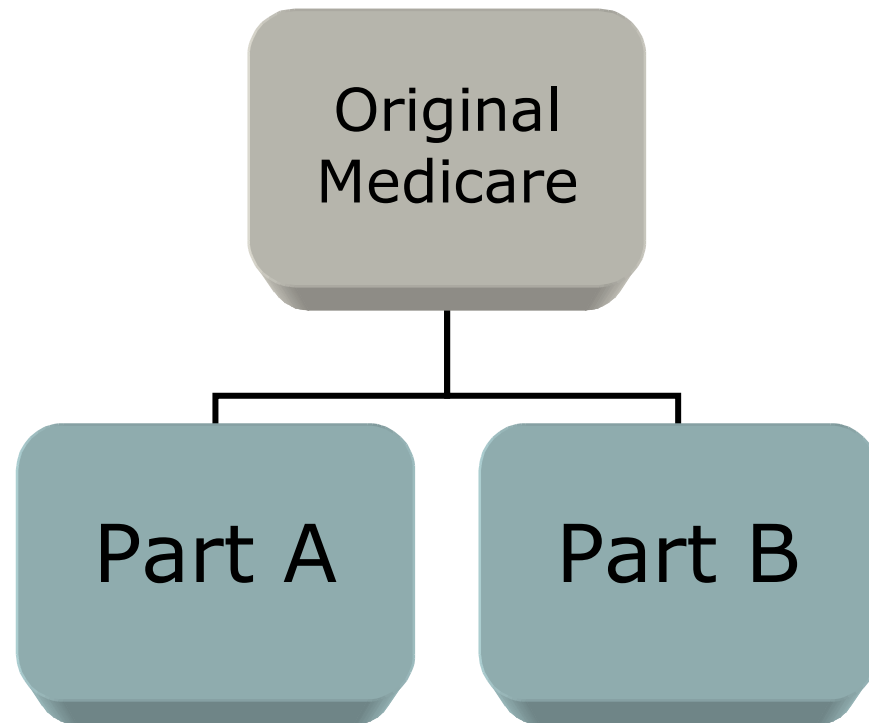


Original Medicare

Original Medicare is a fee-for-service coverage managed by the Federal government. Generally, there is a cost for each service.

Original Medicare consists of **Part A** and **Part B**. You will be in Original Medicare unless you choose a Medicare health plan (such as a Medicare Advantage Plan).

If you are in Original Medicare, you can purchase a Medigap (Medicare Supplement) policy to fill in the coverage gaps that Medicare has. You can also purchase a Medicare Prescription Drug Plan.



Original Medicare Questions

Can I get my health care from any doctor or hospital?	In most cases, yes. You can go to any doctor, supplier, hospital, or other facility that's enrolled in Medicare and is accepting new Medicare patients.
Are prescription drugs covered?	Most prescriptions aren't covered. You can add comprehensive drug coverage by joining a Medicare Prescription Drug Plan (Part D).
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to see a specialist?	No, but the provider must be enrolled in Medicare.
Should I get a supplemental policy?	You may already have employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medigap (Medicare Supplement Insurance) policy.
How much do I pay?	You generally pay a set amount for your health care (deductible) before Medicare pays its share. Then, Medicare pays its share, and you pay your share (coinsurance/copayment) for covered services and supplies. There is no yearly limit for what you pay out-of-pocket. Most people don't pay a monthly premium for Part A; however, most people do pay a monthly premium for Part B (\$115.40 in 2011 for most Medicare enrollees).
Who files the claims?	You generally don't need to file Medicare claims. The law requires providers (like doctors, hospitals, skilled nursing facilities, and home health agencies) and suppliers to file your claims for the covered services and supplies you get.

Original Medicare Costs

Your out-of-pocket costs in Original Medicare depend on the following:

- Whether you have Part A and/or Part B; most people have both
- Whether your doctor or supplier accepts "assignment"
- The type of health care you need and how often you need it
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all the costs unless you have other insurance that covers it
- Whether you have other health insurance (like employer or union coverage) that works with Medicare
- Whether you have Medicaid or get state help paying your Medicare costs
- Whether you have a Medigap (Medicare Supplement Insurance) policy
- Whether you and your doctor sign a private contract

The following two slides show what you may have to pay in out-of-pocket costs if you:

- Have Parts A & B through Original Medicare (and not another Medicare Health Plan such as an Advantage Plan), and
- Do not have a Medigap (Medicare Supplement) policy.

Original Medicare — Part A Out-of-Pocket Costs

Blood	In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated.
Home Health Care	\$0 for home health care services 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	\$0 for hospice care A copayment of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).
Hospital Inpatient Stay	\$1,132 deductible and no coinsurance for days 1–60 each benefit period \$283 per day for days 61–90 each benefit period \$566 per "lifetime reserve day" after day 90 each benefit period (up to 60 days per 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 Stay	\$0 for the first 20 days each benefit period \$141.50 per day for days 21–100 each benefit period All costs for each day after day 100 in a benefit period

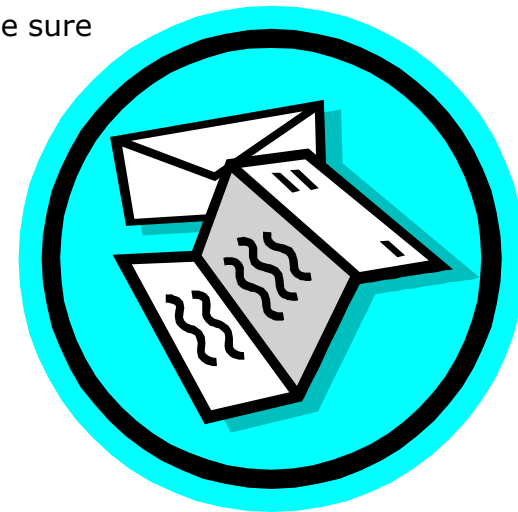
Original Medicare — Part B Out-of-Pocket Costs

Part B Deductible	You pay the first \$162 yearly for Part B-covered services or items.
Blood	In most cases, the provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else. You pay a copayment for additional units of blood you get as an outpatient (after the first 3), and the Part B deductible applies.
Clinical Laboratory Services	You pay \$0 for Medicare-approved services.
Home Health Services	You pay \$0 for Medicare-approved services. You pay 20% of the Medicare-approved amount for durable medical equipment.
Medical and Other Services	You pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.
Mental Health Services	You pay 45% of the Medicare-approved amount for most outpatient mental health care.
Other Covered Services	You pay copayment or coinsurance amounts.
Outpatient Hospital Services	You pay a coinsurance (for doctor services) or a copayment amount for most outpatient hospital services. The copayment for a single service can't be more than the amount of the inpatient hospital deductible.

Medicare Summary Notices

If you get a Medicare-covered service, you will get a Medicare Summary Notice (MSN) in the mail every 3 months. The MSN shows all your services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and what you owe the provider. The MSN isn't a bill. Read it carefully and do the following:

- If you have other insurance, check to see if it covers anything that Medicare didn't.
- Keep your receipts and bills, and compare them to your MSN to be sure you got all the services, supplies, or equipment listed.
- If you paid a bill before you got your MSN, compare your MSN with the bill to make sure you paid the right amount for your services.
- If an item or service is denied, call your doctor's office to make sure they submitted the correct information. If not, the office may resubmit.



Medicare claims can be tracked and MSNs can be viewed online at www.MyMedicare.gov.

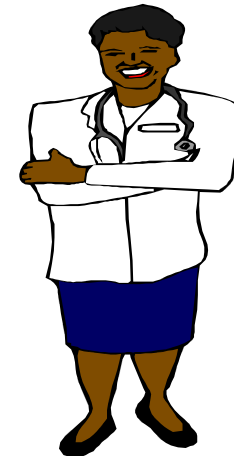
Medicare Assignment

Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare (or is required by law) to accept the Medicare-approved amount as full payment for covered services. Some providers who are enrolled in Medicare don't accept assignment.

Most doctors, providers, and suppliers accept assignment, but you should always check to make sure. To find out if your doctors and suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. In some cases doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicare-covered services. Find out how much you have to pay for each service or supply before you get it.

If your doctor, provider, or supplier **accepts** assignment:

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



If your doctor, provider, or supplier **does not accept** assignment:

- They're supposed to submit a claim to Medicare when they give you Medicare-covered services. They can't charge you for submitting a claim. If they don't submit the claim, you might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back using form CMS-1490S.
- They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you up to 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

Private Contracts

A “private contract” is a written agreement between you and a doctor or other health care provider who has decided not to provide services to anyone through Medicare. The private contract only applies to the services provided by the doctor or other provider who asked you to sign it. You don’t have to sign a private contract. You can always go to another provider who gives services through Medicare. If you sign a private contract with your doctor or other provider, the following rules apply:

- Medicare won’t pay any amount for the services you get from this doctor or provider.
- You will have to pay the full amount of whatever this provider charges you for the services you get.
- If you have a Medigap (Medicare Supplement Insurance) policy, it won’t pay anything for the services you get. Call your Medigap insurance company before you get the service if you have questions.
- Your provider must tell you if Medicare would pay for the service if you got it from another provider who accepts Medicare.
- Your provider must tell you if he or she has been excluded from Medicare.
- You can’t be asked to sign a private contract for emergency or urgent care.
- You’re always free to get services not covered by Medicare if you choose to pay for a service yourself.
- You may want to contact your State Health Insurance Assistance Program (SHIP) to get help before signing a private contract with any doctor or other health care provider.



How Other Insurance Works with Medicare

When you have other insurance (like group health coverage), there are rules that decide whether Medicare or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

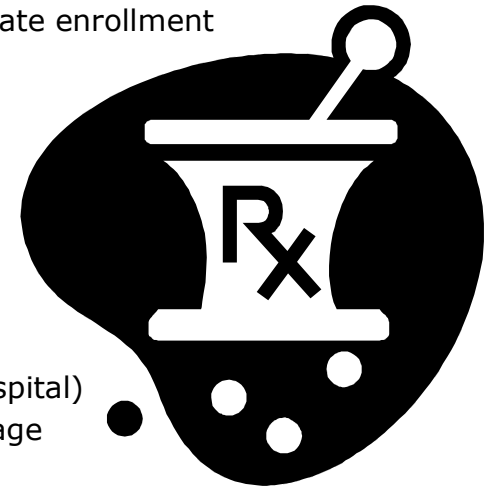
- No-fault insurance and liability (including automobile insurance)
- Black lung benefits and workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

Original Medicare — Adding Drug Coverage

In Original Medicare, if you don't already have creditable prescription drug coverage (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan. These plans are available through private companies under contract with Medicare. If you don't currently have creditable prescription drug coverage, you should think about joining a Medicare Prescription Drug Plan as soon as you're eligible. If you don't join a Medicare Prescription Drug Plan when you're first eligible and you decide to join later, you may have to pay a late enrollment penalty.

If you have creditable prescription drug coverage from an employer or union, call your employer or union's benefits administrator before you make any changes to your coverage. Your employer or union plan will tell you each year if your prescription drug coverage is creditable prescription drug coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union drug coverage without also dropping your employer or union health (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents.



People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs.

Medigap (Medicare Supplement)

Original Medicare pays for many, but not all, health care services and supplies. A Medigap policy, sold by private insurance companies, can help pay some of the health care costs (“gaps”) that Original Medicare doesn’t cover, like copayments, coinsurance, and deductibles. Some Medigap policies also offer coverage for services that Original Medicare doesn’t cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share. Medicare doesn’t pay any of the premiums for a Medigap policy.

Every Medigap policy must follow Federal and state laws designed to protect you, and it must be clearly identified as “Medicare Supplement Insurance.” Medigap insurance companies can sell you only a “standardized” Medigap policy identified in most states by letters. All plans offer the same basic benefits but some offer additional benefits, so you can choose which one meets your needs.

“Standardized” Medigap policy plans are identified by the letters: A, B, C, D, F, G, K, L, M, and N. A policy plan sold by one insurance company provides exactly the same coverage as that same policy plan sold by another insurance company. However, insurance companies may charge different premiums for exactly the same Medigap policy plan.

Note: In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

Recent Medigap Changes

Major changes to “Standardized” Medigap policies became effective on June 1, 2010.

- There are two new Medigap Plans — Plans M and N.
- Plans E, H, I, and J are no longer available to buy. If you bought Plan E, H, I, or J before June 1, 2010, you can keep that plan. Contact your plan for more information.



Buying a Medigap Policy

- You must have Part A and Part B to buy a Medigap policy.
- You pay a monthly premium for your Medigap policy in addition to your monthly Part B premium.
- A Medigap policy only covers one person. Spouses must buy separate policies.
- It's important to compare Medigap policies since the costs can vary and may go up as you get older. Some states limit Medigap costs.
- The best time to buy a Medigap policy is during the 6-month period that begins on the first day of the month in which you're 65 or older and enrolled in Part B. (Some states have additional open enrollment periods.) After this enrollment period, your option to buy a Medigap policy may be limited and it may cost more. For example, if you turn 65 and are enrolled in Part B in June, the best time for you to buy a Medigap policy is from June to November.
- If you're under 65, you won't have this open enrollment period until you turn 65, but state law might give you a right to buy a policy before then.
- You can't have prescription drug coverage in both your Medigap policy and a Medicare drug plan.



Medigap Policies & Medicare Advantage

If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you may want to drop your Medigap policy. Your Medigap policy can't be used to pay your Medicare Advantage Plan copayments, deductibles, and premiums. If you want to cancel your Medigap policy, contact your insurance company. If you drop your policy to join a Medicare Advantage Plan, in most cases you won't be able to get it back.

If you have a Medicare Advantage Plan, it's illegal for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. Contact your State Insurance Department if this happens to you.

If you join a Medicare health plan (e.g. Advantage Plan) for the first time, and you aren't happy with the plan, you will have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining.

- If you had a Medigap policy before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another Medigap policy.
- The Medigap policy can no longer have prescription drug coverage even if you had it before, but you may be able to join a Medicare Prescription Drug Plan.
- If you joined a Medicare health plan (e.g. Advantage Plan) when you were first eligible for Medicare, you can choose from any policy.

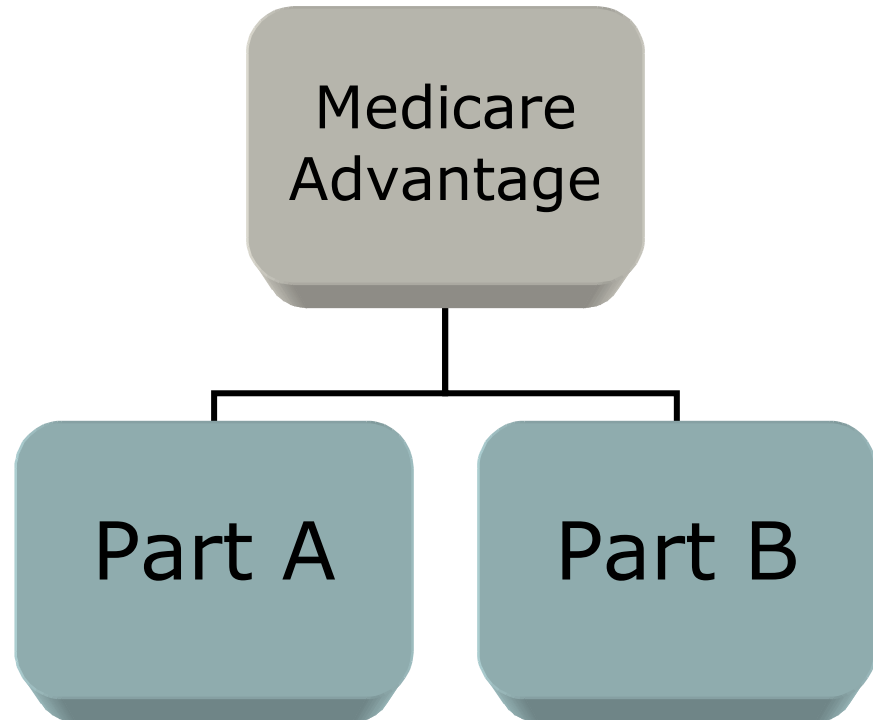
Part C — Medicare Advantage Plans

A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare.

If you join a Medicare Advantage Plan, the plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all types of Medicare Advantage Plans, you’re always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you’re in a Medicare Advantage Plan. Medicare Advantage Plans aren’t supplemental coverage.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you usually pay one monthly premium for the services included.

Medicare pays a fixed amount for your care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care). These rules can change each year.



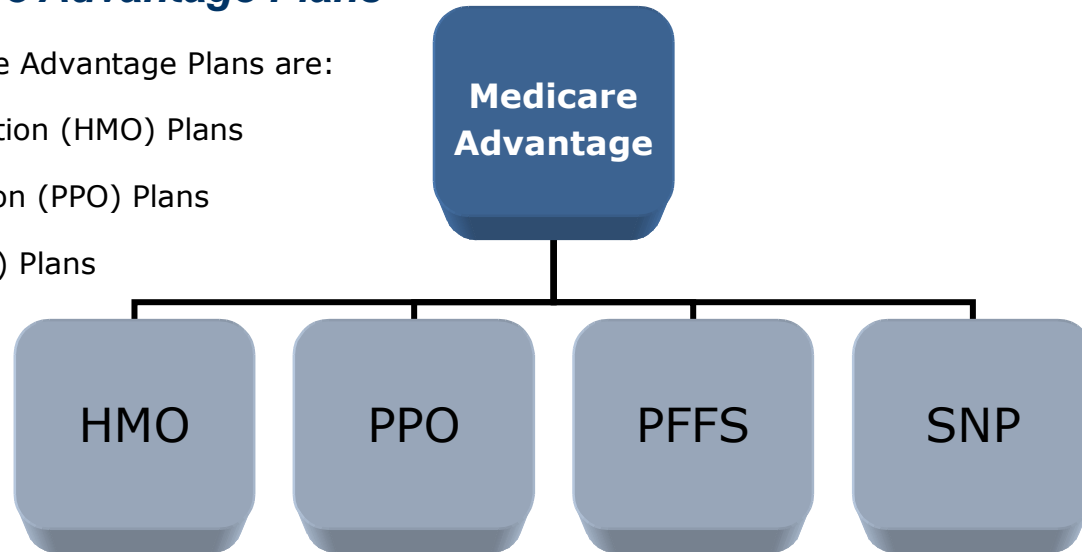
Part C — Types of Medicare Advantage Plans

The most common types of Medicare Advantage Plans are:

- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Private Fee-for-Service (PFFS) Plans
- Special Needs Plans (SNP)

The less common types of Medicare Advantage Plans include:

- HMO Point-of-Service (HMOPOS) Plans—An HMO plan that may allow you to get some services out-of-network for a higher cost.
- Medical Savings Account (MSA) Plans—A plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year.



Part C — Medicare Advantage Plan Rules

- As with Original Medicare, you still have Medicare rights and protections, including the right to appeal.
- Check with the plan before you get a service to find out whether they will cover the service and what your costs may be.
- You must follow plan rules, like getting a referral to see a specialist to avoid higher costs if your plan requires it. Check with the plan.
- You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease.
- You can only join or leave a plan at certain times during the year.
- If you go to a doctor, facility, or supplier that doesn't belong to the plan, your services may not be covered, or your costs could be higher, depending on the type of Medicare Advantage Plan. In most cases, this applies to Medicare Advantage HMOs and PPOs.
- If the plan decides to stop participating in Medicare, you will have to join another Medicare health plan or return to Original Medicare.
- You usually get prescription drug coverage (Part D) through the plan. In some types of plans that don't offer drug coverage, you can join a Medicare Prescription Drug Plan. If you're in a Medicare Advantage Plan that includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you will be dis-enrolled from your Medicare Advantage Plan and returned to Original Medicare. You can't have prescription drug coverage through both a Medicare Advantage Plan and a Medicare Prescription Drug Plan.
- You don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance) policy while you're in a Medicare Advantage Plan. It won't cover your Medicare Advantage Plan deductibles, copayment, or coinsurance.

Part C — Medicare Advantage Plan Rules (cont.)

- If you join a clinical research study, your costs may be lower and some costs may be covered by your plan.
- Medicare Advantage Plans can't charge you more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.
- Medicare Advantage Plans will have an annual cap on how much you pay for Part A and Part B services during the year. This annual maximum out of pocket amount can be different between Medicare Advantage Plans.

Part C — Joining a Medicare Advantage Plan

You can generally join a Medicare Advantage Plan if you meet these conditions:

- You have Part A and Part B.
- You live in the service area of the plan.
- You don't have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). There are some exceptions to this rule.
- In most cases, you can join a Medicare Advantage Plan only at certain times during the year.

Part C — Medicare Advantage & Other Coverage

Talk to your employer, union, or other benefits administrator about their rules before you join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause you to lose employer or union coverage. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the plan you join. Remember, if you drop your employer or union coverage, you may not be able to get it back.

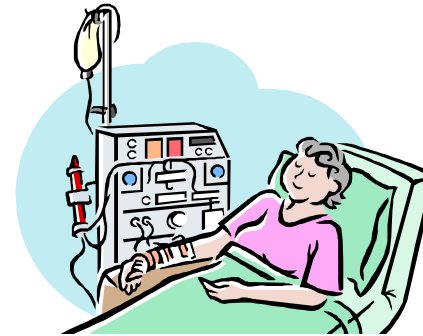
Part C — Medicare Advantage & Medigap Policies

If you have a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO), you will probably want to drop your Medigap policy. You can't use it to pay for any expenses (copayments, deductibles, and premiums) you have under a Medicare Advantage Plan. If you drop your Medigap policy, you may not be able to get it back.

Part C — Medicare Advantage & End Stage Renal Disease (ESRD)

If you have End-Stage Renal Disease (ESRD), you usually can't join a Medicare Advantage Plan. However, you may be able to join a Medicare Advantage Plan in the following situations:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in your plan or join another plan offered by the same company under certain circumstances.
- If you have an employer or union health plan or other health coverage through a company that offers Medicare Advantage Plans, you may be able to join one of their Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.
- You may be able to join a Medicare Special Needs Plan (SNP) for people with ESRD if one is available in your area.



If you have ESRD and are in a Medicare Advantage Plan, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan. You don't have to use your one-time right to join a new plan immediately. If you go directly to Original Medicare after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later.

Note: If you have ESRD and Original Medicare, you may join a Medicare Prescription Drug Plan.

Part C — Medicare Advantage: Out-of-Pocket Costs

Your out-of-pocket costs in a Medicare Advantage Plan depend on the following:

- Whether the plan charges a monthly premium
- Whether the plan pays any of your monthly Part B premium
- Whether the plan has a yearly deductible or any additional deductibles
- How much you pay for each visit or service (copayments or coinsurance)
- The type of health care services you need and how often you get them
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra benefits and if the plan charges for it
- The plan's yearly limit on your out-of-pocket costs for all medical services



If you have limited income and resources, you may qualify for the following:

- Extra Help paying your premium and other prescription drug coverage costs under Part D.
- Help from your state to pay your Medicare premiums. In some cases, the state may also pay your Part A and Part B deductibles and coinsurance.

If you're in a Medicare plan, review the Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) your plan sends you each fall. The EOC gives you details about what the plan covers, how much you pay, and more. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.

Part C — Medicare Advantage: How does it Work?

	HMO	PPO	PFFS	SNP
Can I get my health care (other than emergency and urgent care) from any doctor or hospital?	No. You generally must get your care and services from doctors or hospitals in the plan's network.	In most cases, yes. PPOs have network doctors and hospitals, but you can also use out of network providers for covered services, usually for a higher cost.	In some cases, yes.	No. You generally must get your care and services from doctors or hospitals in the plan's network.
Are prescription drugs covered?	In most cases, yes.	In most cases, yes.	Sometimes. If your PFFS Plan doesn't offer drug coverage, you can join a Medicare PDP.	Yes.
Do I need to choose a primary care doctor?	In most cases, yes.	No.	No.	Generally, yes.
Do I have to get a referral to see a specialist?	In most cases, yes.	No.	No.	In most cases, yes.

Part C — Medicare Advantage: Join, Switch, or Drop a Plan

You can join, switch, or drop a Medicare Advantage Plan at these times:

- When you first become eligible for Medicare (the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability.
- Between October 15–December 7 in 2011. Your coverage will begin on January 1, 2012, as long as the plan gets your enrollment request by December 31.
- Between January 1–February 14, 2011, if you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare. If you switch to Original Medicare during this period, you will have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form. During this period, you can't:
 - Switch from Original Medicare to a Medicare Advantage Plan
 - Switch from one Medicare Advantage Plan to another
 - Switch from one Medicare Prescription Drug Plan to another
 - Join, switch, or drop a Medicare Medical Savings Account Plan

In most cases, you must stay enrolled for that calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop a Medicare Advantage Plan at these times:

- If you move out of your plan's service area
- If you qualify for Extra Help
- If you live in an institution (like a nursing home)

Part C — Medicare Advantage: How Do You Join?

If you choose to join a Medicare Advantage Plan, you may be able to join by doing one of the following:

- Completing a paper application,
- Calling the plan,
- Enrolling on the plan's Web site or on www.medicare.gov, or
- Calling 1-800-MEDICARE (1-800-633-4227).

When you join a Medicare Advantage Plan, you will have to provide your Medicare number and the date your Part A and/or Part B coverage started. This information is on your Medicare card.

Part C — Medicare Advantage: How Do You Switch?

If you're already in a Medicare Advantage Plan and want to switch, this is what you need to do:

- To switch to a new Medicare Advantage Plan, simply join the plan you choose during one of the enrollment periods. You will be disenrolled automatically from your old plan when your new plan's coverage begins.
- To switch to Original Medicare, contact your current plan, or call 1-800-MEDICARE. You will also need to decide about Medicare prescription drug coverage (Part D) and if you want a Medigap (Medicare Supplement Insurance) policy.



Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug coverage). These plans have some of the same rules as Medicare Advantage Plans. Some of these rules are explained briefly below and on the next pages. 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 Cost Plans

Medicare Cost Plans are a type of Medicare health plan available in certain areas of the country. Here's what you should know about Medicare Cost Plans:

- You can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. You would pay the Part A and Part B coinsurance and deductibles.
- You can join anytime the plan is accepting new members.
- You can leave anytime and return to Original Medicare.
- You can either get your Medicare prescription drug coverage from the plan (if offered), or you can join a Medicare Prescription Drug Plan. Note: You can add or drop Medicare prescription drug coverage only at certain times.

There is another type of Medicare Cost Plan that only provides coverage for Part B services. These plans never include Part D. Part A services are covered through Original Medicare. These plans are either sponsored by employer or union group health plans or offered by companies that don't provide Part A services.

Demonstrations / Pilot Programs

Demonstrations and pilot programs, sometimes called “research studies,” are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas. Check with the demonstration or pilot program for more information about how it works.

Programs of All-Inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community.

- To qualify for PACE, you must meet the following conditions:
- You’re 55 or older.
- You live in the service area of a PACE organization.
- You’re certified by your state as needing a nursing home level of care.
- At the time you join, you’re able to live safely in the community with the help of PACE services.

PACE provides coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary. If you have Medicare, Medicare pays for all Medicare-covered services. If you have Medicare and Medicaid, you will either have a small monthly payment or pay nothing for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.

Part D — Medicare Prescription Drug Coverage



Medicare offers prescription drug coverage to everyone with Medicare. Even if you don't take a lot of prescriptions now, you should still consider joining a Medicare drug plan. To get Medicare prescription drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered. 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, you will likely pay a late enrollment penalty.

Part D — Getting Prescription Drug Coverage

There are two ways to get Medicare prescription drug coverage:

- Medicare Prescription Drug Plans (PDPs) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
- Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.”

Both types of plans are called “Medicare drug plans.”

To join a Medicare Prescription Drug Plan, you must have Medicare Part A or Part B. To join a Medicare Advantage Plan, you must have Part A and Part B. You must also live in the service area of the Medicare drug plan you want to join.

If you have employer or union coverage, call your benefits administrator before you make any changes, or before you sign up for any other coverage. If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union drug coverage without also dropping your employer or union health (doctor and hospital) coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents. If you want to know how Medicare prescription drug coverage works with other drug coverage you may have.

Part D — Medicare Drug Plans: Join, Switch, or Drop

You can join, switch, or drop a Medicare drug plan at these times:

- When you're first eligible for Medicare (the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65).
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability. You will have another chance to join 3 months before the month you turn 65 to 3 months after the month you turn 65.
- Between October 15–December 7 in 2011. Your coverage will begin on January 1, 2012, as long as the plan gets your enrollment request by December 31.
- Anytime, if you qualify for Extra Help.

In most cases, you must stay enrolled for that calendar year starting the date your coverage begins. However, in certain situations, you may be able to join, switch, or drop Medicare drug plans at other times. Some of these situations include the following:

- If you move out of your plan's service area
- If you lose other creditable prescription drug coverage
- If you live in an institution (like a nursing home)

If you want to join a plan or switch plans, do so as soon as possible so you will have your membership card when your coverage begins, and you can get your prescriptions filled without delay.

If you have limited income and resources, you may qualify for Extra Help to pay for Medicare prescription drug coverage. You may also be able to get help from your state.

Part D — Medicare Drug Plans: How Do You Join?

Once you choose a Medicare drug plan, you may be able to join by:

- Completing a paper application
- Calling the plan
- Enrolling on the plan's Web site or on www.medicare.gov
- Calling 1-800-MEDICARE (1-800-633-4227)

When you join a Medicare drug plan, you will have to provide your Medicare number and the date your Part A and/or Part B coverage started. This information is on your Medicare card.



Part D — Medicare Drug Plans: How Do You Switch?

You can switch to a new Medicare drug plan simply by joining another drug plan during one of the times listed previously. You don't need to cancel your old Medicare drug plan or send them anything. Your old Medicare drug plan coverage will end when your new drug plan begins. You should get a letter from your new Medicare drug plan telling you when your coverage begins.

If you want to drop your Medicare drug plan and don't want to join a new plan, you can do so during one of the times listed previously. You can dis-enroll by calling 1-800-MEDICARE. You can also send a letter to the plan to tell them you want to dis-enroll. If you drop your plan and want to join another Medicare drug plan later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty.

If your Medicare Advantage Plan includes prescription drug coverage and you join a Medicare Prescription Drug Plan, you will be dis-enrolled from your Medicare Advantage Plan and returned to Original Medicare.

Part D — Medicare Drug Plans: What You Pay

Below and continued on the next page are descriptions of the payments you make throughout the year in a Medicare drug plan. Your actual drug plan costs will vary depending on the prescriptions you use, the plan you choose, whether you go to a pharmacy in your plan's network, whether your drugs are on your plan's formulary (drug list), and whether you get Extra Help paying your Part D costs.

Part D — Medicare Drug Plans: Monthly Premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you belong to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium you pay to your plan may include an amount for prescription drug coverage.

Note: Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once. After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans.



Your Part D monthly premium could be higher based on your income. This includes Part D coverage you get from a Medicare Prescription Drug Plan, or a Medicare Advantage Plan or Medicare Cost Plan that includes Medicare prescription drug coverage. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you will pay a higher monthly premium.

Part D — Medicare Drug Plans: Yearly Deductible

The amount you must pay before your drug plan begins to pay its share of your covered drugs. Some drug plans don't have a deductible.

Part D — Medicare Drug Plans: Copayments or Coinsurance

Amounts you pay at the pharmacy for your covered prescriptions after the deductible (if the plan has one). You pay your share, and your drug plan pays its share for covered drugs.

Part D — Medicare Drug Plans: Catastrophic Coverage

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

Note: If you get Extra Help paying your drug costs, you won't have a coverage gap and will pay only a small or no copayment once you reach catastrophic coverage.



Part D — Medicare Drug Plans: Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Not everyone will reach the coverage gap. Your yearly deductible, your coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn’t include the drug plan premium you pay or what you pay for drugs that aren’t covered.



There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. Check with the drug plan first to see if your drugs would be covered during the gap.

If you reached the coverage gap in 2010, (and you weren’t already getting Extra Help), you may have received a one-time \$250 rebate check to help you with your drug costs.

If you reach the coverage gap in 2011, you will get a 50% discount on covered brand-name prescription drugs at the time you buy them. There will be additional savings for you in the coverage gap each year through 2020 when you will have full coverage in the gap. Talk to your doctor or other health care provider to make sure that you’re taking the lowest cost drug available that works for you.

Part D — Medicare Drug Plans: Late Enrollment Penalty

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a late enrollment penalty if one of the following is true:

- You didn't join a Medicare drug plan when you were first eligible for Medicare, and you didn't have other creditable prescription drug coverage.
- You didn't have Medicare prescription drug coverage or other creditable prescription drug coverage for 63 days or more in a row.



Note: If you get Extra Help, you don't pay a late enrollment penalty.

Here are a few ways to avoid paying a penalty:

- Join a Medicare drug plan when you're first eligible. You won't have to pay a penalty, even if you've never had prescription drug coverage before.
- Don't go 63 days or more in a row without a Medicare drug plan or other creditable coverage. Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, Department of Veterans Affairs, or health insurance coverage. Your plan will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
- Tell your plan about any drug coverage you had if they ask about it. When you join a plan, and they believe you went at least 63 days in a row without other creditable prescription drug coverage, they will send you a letter. The letter will include a form asking about any drug coverage you had. Complete the form. If you don't tell the plan about your creditable coverage, you may have to pay a penalty.

Part D — Medicare Drug Plans: Late Enrollment Penalty Amount

The cost of the late enrollment penalty depends on how long you didn't have creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" (\$32.34 in 2011) 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 every year. You may have to pay this penalty for as long as you have a Medicare drug plan.



Example: Mrs. Jones didn't join when she was first eligible—by May 15, 2007. She joined a Medicare drug plan between November 15—December 31, 2010, for an effective date of January 1, 2011. Since Mrs. Jones didn't join when she was first eligible and went without other creditable drug coverage for 43 months (June 2007–December 2010), she will be charged a monthly penalty of \$13.90 in 2011 ($\$32.34 \times 0.01 = \$.3234 \times 43 = \13.90) in addition to her plan's monthly premium.

When you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be.

Part D — Medicare Drug Plans: Late Enrollment Penalty Appeal

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

Part D — Medicare Drug Plans: Important Rules

The following information can help answer common questions as you begin to use your coverage.

To fill a prescription before you get your membership card, you should get a welcome package with your membership card within 5 weeks or sooner after the plan gets your completed application. If you need to go to the pharmacy before your membership card arrives, you can use any of the following as proof of membership:

- A letter from the plan that includes your complete membership information
- An enrollment confirmation number that you got from the plan, the plan name, and telephone number
- A temporary card that you may be able to print from MyMedicare.gov

If you don't have any of the items listed above, and your pharmacist can't get your drug plan information any other way, you may have to pay out-of-pocket for your prescriptions. If you do, save the receipts and contact your plan to get your money back.

Information about a plan's list of covered drugs (called a formulary) isn't included in this handbook because each plan has its own formulary. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception to ask your plan for a lower copayment.

Note: Medicare drug plans must cover all commercially-available vaccines (like the shingles vaccine) when medically necessary to prevent illness except for vaccines covered under Part B.

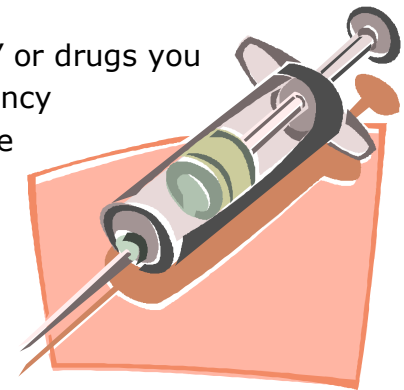
Part D — Medicare Drug Plans: Important Rules (cont.)

Drug plan coverage rules include:

- Prior authorization — you and/or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) must contact the drug plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is medically necessary for the plan to cover it.
- Quantity limits — limits on how much medication you can get at a time.
- Step therapy — you must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

If you or your prescriber believes that one of these coverage rules should be waived, you can ask for an exception.

In most cases, the prescription drugs (sometimes called “self-administered drugs” or drugs you would normally take on your own) you get in an outpatient setting like an emergency department or during observation services aren’t covered by Part B. Your Medicare drug plan may cover these drugs under certain circumstances. You will likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Or, if you get a bill for self-administered drugs you got in a doctor’s office, call your Medicare drug plan (Part D) for more information.



Part D — Medicare Drug Plans & Other Private Insurance

As shown below, other insurance you may have works with, or is affected by, Medicare prescription drug coverage (Part D).

- **Employer or Union Health Coverage**—Health coverage from your, your spouse’s, or other family member’s current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your prescription drug coverage is creditable. Keep the information you get. Call your benefits administrator for more information before making any changes to your coverage. Note: If you join a Medicare drug plan, you, your spouse, or your dependents may lose your employer or union health coverage.
- **COBRA**—A Federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of, or in addition to, COBRA. However, if you take COBRA and it includes creditable prescription drug coverage, you will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends. Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you.
- **Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage**—Medigap policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Medigap policy, you can keep it. However, it may be to your advantage to join a Medicare drug plan because most Medigap drug coverage isn’t creditable. If you join a Medicare drug plan, your Medigap insurance company must remove the prescription drug coverage under your Medigap policy and adjust your premiums. Call your Medigap insurance company for more information.



Part D — Medicare Drug Plans & Other Government Insurance

The types of insurance listed below are all considered creditable prescription drug coverage. If you have one of these types of insurance, in most cases, it will be to your advantage to keep your current coverage.

- Federal Employee Health Benefits (FEHB) Program—Health coverage for current and retired Federal employees and covered family members. FEHB plans usually include prescription drug coverage, so you don't need to join a Medicare drug plan. However, if you do decide to join a Medicare drug plan, you can keep your FEHB plan, and your plan will let you know who pays first.
- Veterans' Benefits—Health coverage for veterans and people who have served in the U.S. military. You may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if you do, you can't use both types of coverage for the same prescription at the same time.
- TRICARE (Military Health Benefits)—Health care plan for active-duty service members, retirees, and their families. Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits. If you have TRICARE, you don't need to join a Medicare Prescription Drug Plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second. If you join a Medicare Advantage Plan with prescription drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy.
- Indian Health Services—Health care services for American Indians and Alaska Natives. Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you will continue to get drugs at no cost to you and your coverage won't be interrupted. Joining a Medicare drug plan may help your Indian health facility because the drug plan pays the Indian health facility for the cost of your prescriptions. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

