

Medicare Made Clear™

Brought to you by **UnitedHealthcare**

A simple guide to understanding Medicare



Welcome

You have important decisions to make when you become eligible for Medicare. Our goal is to help you understand your options and feel confident about choosing coverage based on your needs — when you first enroll and every year after that.

We're here to help.

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Eligibility and enrollment

Medicare is a federal program that offers health insurance to American citizens and other eligible individuals.

New Medicare Card

Medicare cards will have a new look starting in April 2018. Your card will have a unique ID number just for you. Social Security numbers will no longer appear on Medicare cards. New cards will be issued to current beneficiaries over time, from April 2018 to April 2019. You may continue to use your current card until your new one arrives.

Who can get Medicare?

U.S. citizens and legal residents

Legal residents must live in the U.S. for at least 5 years in a row, including the 5 years just before applying for Medicare.

You must also meet one of the following requirements:

- Age 65 or older
- Younger than 65 with a qualifying disability
- Any age with a diagnosis of end-stage renal disease or ALS

How do you enroll?

- You should be automatically enrolled in Medicare **Part A** and **Part B** if you are receiving Social Security or Railroad Retirement Board benefits when you become eligible. You'll receive your Medicare card in the mail.
- You need to enroll in Medicare yourself if you aren't receiving Social Security benefits when you become eligible. Go to SSA.gov/Medicare to enroll online, or call or visit your local Social Security office.



Turning 65

You are eligible for Medicare at age 65.

Your **Initial Enrollment Period** (IEP) is 7 months long. It includes the month you turn 65, the 3 months before and the 3 months after. It begins and ends a month earlier if your birthday is the first day of the month.

Sign up early.

Coverage begins the first day of your 65th birthday month if your enrollment is completed during the first 3 months of your IEP. It begins the month before if your birthday is on the first. Your coverage start date may be delayed if you sign up later.

You have choices.

You may enroll in Medicare Part A (hospital insurance), Medicare Part B (medical insurance) or both. You may have other coverage choices once you enroll in Medicare, such as a **Medicare Advantage plan (Part C)**, a **prescription drug plan (Part D)** or a **Medicare supplement insurance plan**.

Working past 65

You still have an Initial Enrollment Period.

You have Medicare decisions to make at age 65 even if you have coverage through an employer plan (yours or your working spouse's). Your IEP happens when you turn 65 whether you continue to work or not.

Be proactive.

Make sure you know your IEP dates. Medicare will not notify you about your eligibility unless you are receiving Social Security or Railroad Retirement Board benefits when you turn 65.

Medicare may work with employer coverage.

Many people with employer coverage enroll in just Part A during their IEP. Part A is premium free for most people, and it may provide secondary hospital coverage after an employer plan. Some employers require you to take full Medicare benefits (Parts A and B) at age 65. Check with your employer plan benefits administrator.

Medicare enrollment based on disability or medical condition

You will be automatically enrolled in Medicare Parts A and B. You may make other coverage choices during your IEP. Your 7-month IEP includes the month you receive your 25th disability check plus the 3 months before and the 3 months after. Enrollment timing for people with end-stage renal disease or ALS is based on the time of diagnosis and other factors.

Coverage choices

Original Medicare (Parts A and B) helps pay for doctor visits and hospital stays, but it doesn't cover everything — and it doesn't cover prescription drugs.


Many people choose additional coverage by enrolling in one or more private Medicare or Medicare-related plans.


- **Medicare supplement insurance plans (Medigap)** help pay some of the out-of-pocket costs that come with Original Medicare.
- **Medicare prescription drug plans (Part D)** help pay for medications prescribed by a doctor or other health care professional.
- **Medicare Advantage plans (Part C)** combine Part A, Part B and often prescription drug coverage (Part D). Some plans may offer additional benefits like coverage for routine vision and dental care.

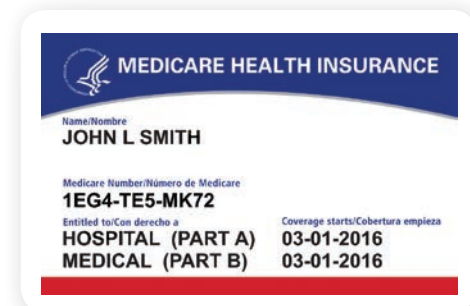
STEP 1

Enroll in Original Medicare.

Original Medicare Provided by the federal government

PART A  Helps pay for hospital stays and inpatient care

PART B  Helps pay for doctor visits and outpatient care



STEP 2

Decide if you need additional coverage. There are two ways to get it.

OPTION 1

OR

OPTION 2

Add one or both of the following to Original Medicare.

Choose a Medicare Advantage plan.

Medicare Supplement Insurance Plan Offered by private companies



Helps pay some of the out-of-pocket costs that come with Original Medicare

Medicare Part D Plan Offered by private companies



Helps pay for prescription drugs

Medicare Advantage Plan Offered by private companies



Combines Part A (hospital insurance) and Part B (medical insurance) in one plan



Usually includes prescription drug coverage



May offer additional benefits not provided by Original Medicare

Out-of-pocket costs

Medicare isn't free. The amount you'll pay depends on the coverage you choose and the health care services you receive.

Medicare and most Medicare plans charge monthly premiums. A **premium** is a fixed amount you pay for coverage.

You'll also pay a share of the cost for your care. There are three methods of cost sharing:

- **Deductible**
- **Copay**
- **Coinsurance**

Consider all the costs

It's easy to focus on just premiums when comparing your Medicare choices. But a low premium might come with high deductibles, copays or coinsurance rates.

Deductible

A set amount you pay out of pocket for covered services before Medicare or your Medicare plan begins to pay.



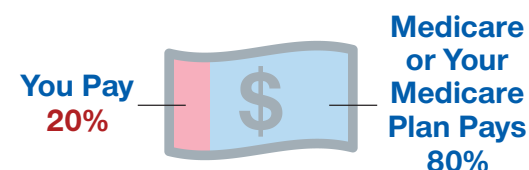
Copay

A fixed amount you pay at the time you receive a covered service. For example, you might pay \$20 when you visit the doctor or \$12 when you fill a prescription.



Coinsurance

A percentage of the cost for a covered service that you pay when you receive it. For example, you might pay 20% and Medicare or your Medicare plan would pay the remaining 80%.



Help with Medicare costs

If you have a low income and few assets, you may qualify for help through one or more of the following programs. There may also be other assistance programs in your state.

Income includes money you get from retirement benefits or other money that you report for tax purposes. Income eligibility levels vary by state and program.

Medicaid

Medicaid provides health care coverage for people and families with limited incomes. It may also offer some services not covered by Medicare. Each state creates its own program, so contact your state Medicaid office for more information.

If you qualify for both Medicare and Medicaid, you are **"dual eligible."** Sometimes the two programs can work together to cover most of your health care costs.

Extra Help

The Extra Help program helps pay some or all Part D premiums, deductibles and copays.

Medicare Savings Programs

Medicare Savings Programs help pay some or all Part A and Part B premiums, deductibles and coinsurance. You automatically qualify for the Extra Help program if you qualify for a Medicare Savings Program.

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

PACE combines medical, social and long-term care services for frail elderly people who live in the community, not in a nursing home. This program is not available in all states.

Find out if you qualify for help

Many people assume they don't qualify for financial help, and they never look into it. Don't make that mistake. Visit [Medicare.gov](https://www.Medicare.gov) to learn more about financial assistance programs. You may also contact your local Social Security office, Medicaid office or State Health Insurance Assistance Program for help.

Quick tips

1 There are two ways to get Medicare coverage.

- You can choose Original Medicare (Parts A and B). Part A is hospital coverage and Part B is medical coverage. Original Medicare is provided by the federal government. Benefits and coverage are the same across the country.
- Or you can join a Medicare Advantage plan (Part C). Medicare Advantage plans combine Part A and Part B coverage. Many also include prescription drug coverage (Part D) and offer additional benefits. Plans are offered by private insurance companies.

2 You will pay a share of your costs.

- Neither Original Medicare nor a Medicare Advantage plan will pay for everything.
- You are responsible for monthly premiums as well as out-of-pocket costs such as deductibles, copays and coinsurance.

3 Protection from high out-of-pocket costs is available.

- Medicare Advantage plans put a cap on your out-of-pocket costs for covered services. It's called the "annual out-of-pocket maximum" and it provides built-in financial protection. There is no out-of-pocket cap with Original Medicare.
- Medicare supplement insurance plans help pay some out-of-pocket costs not paid by Original Medicare, like deductibles and coinsurance. Plans are sold by private insurance companies.
- You don't need and can't use a Medicare supplement insurance plan if you have a Medicare Advantage plan.

4 There are two ways to get drug coverage.

- You may add a standalone prescription drug plan (Part D) to Original Medicare.
- Or you may enroll in a Medicare Advantage plan that includes prescription drug coverage.
- Plans are offered by private insurance companies.

5 You may have many options.

- Medicare Advantage plans and prescription drug plans vary in terms of coverage and cost. Insurance companies may offer several plans where you live.
- Medicare supplement insurance plans are standardized and are the same nationwide, except in Minnesota, Wisconsin and Massachusetts.

6 Timing matters when you first enroll.

- Your Initial Enrollment Period (IEP) is your first chance to enroll in Medicare and choose the coverage you want. Your IEP is 7 months long. It includes your birthday month or the 25th month of getting disability benefits plus the 3 months before and 3 months after.
- You are automatically enrolled in Part A and Part B if you are receiving Social Security or Railroad Retirement Board benefits when you become eligible for Medicare. Otherwise you must enroll yourself.

- Medicare Part A, Part B and Part D may charge penalties if you sign up after your IEP ends, unless you qualify for a Special Enrollment Period.

7 It's wise to review your choices every year.

- Medicare Open Enrollment happens each year from October 15 to December 7. You may change your coverage choices during this time if you decide to.
- You may switch from one Medicare Advantage plan or prescription drug plan to another. You may also switch from Original Medicare to a Medicare Advantage plan, or vice versa.
- Changes go into effect on January 1.

8 You may enroll or make changes at other times.

- Medicare provides Special Enrollment Periods for qualifying life events. Examples include moving your primary residence or leaving an employer health plan.
- Visit [Medicare.gov](https://www.Medicare.gov) for a complete list of qualifying events.

Medicare Parts A and B: Original Medicare

Original Medicare includes Part A (hospital insurance) and Part B (medical insurance). It covers care received from any qualified provider in the United States that is enrolled in Medicare and accepting Medicare patients.

PART A Helps pay for hospital stays

PART B Helps pay for doctor visits and outpatient care

What Part A covers

Medicare Part A covers hospital stays and inpatient care, including:

- A semi-private room
- Your hospital meals
- Skilled nursing services
- Care in special units, such as intensive care
- Drugs, medical supplies and medical equipment used during an inpatient stay
- Lab tests, X-rays and medical equipment as an inpatient
- Operating room and recovery room services
- Some blood transfusions in a hospital or skilled nursing facility
- Inpatient or outpatient rehabilitation services after a qualified inpatient stay
- Part-time, skilled care for the homebound
- Hospice care** for the terminally ill, including medications care to manage symptoms and control pain

What isn't covered by Part A

- Personal expenses while hospitalized, such as a TV or phone
- **Custodial care** (care that helps with daily life activities like eating and bathing)
- Long-term care
- Most care outside of the United States
- Days spent in a psychiatric hospital beyond certain set limits
- Hospital days beyond certain set limits

What Part B covers

Medicare Part B covers doctor visits and outpatient care, including:

- Doctor visits, including when you are in the hospital
- An annual wellness visit and preventive services, like flu shots and mammograms
- Clinical laboratory services, like blood and urine tests
- X-rays, MRIs, CT scans, EKGs and some other diagnostic tests
- Some health programs, like smoking cessation, obesity counseling and cardiac rehab
- Physical therapy, occupational therapy and speech-language pathology services
- Diabetes screenings, diabetes education and certain diabetes supplies
- Mental health care
- Durable medical equipment for use at home, like wheelchairs and walkers
- Ambulatory surgery center services
- Ambulance and emergency room services
- Skilled nursing care and health aide services for the homebound on a part-time or intermittent basis

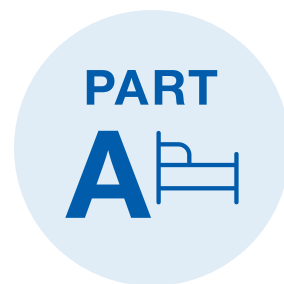
What isn't covered by Part B

- Eye exams, eyeglasses or contact lenses
- Hearing tests or hearing aids
- Dental exams, cleanings, X-rays or routine dental care
- Most prescription drugs

Part B coverage limits

Preventive services and screenings are covered on set schedules, such as a yearly flu shot. Other services and supplies must be medically necessary to diagnose or treat a disease or condition.

What you pay for Part A



Premium

You do not pay a Part A premium if you or your spouse made payroll contributions to Social Security for at least 10 years (40 quarters). Otherwise, your 2018 monthly premium will be up to \$422.

Your Part A premium, if you owe one, may be higher if you don't sign up for Medicare when you are first eligible.

Deductible

Part A deductibles are charged per **benefit period**. A benefit period begins the day you are admitted to the hospital and ends when you've been out of the hospital 60 days in a row.

You pay one deductible even if you have more than one hospital stay during a single benefit period. The 2018 Part A deductible is \$1,340.

Copay

There is no copay for hospital stays up to 60 days in one benefit period. Copays for a longer stay may include:

- \$335 per day for days 61–90
- \$670 per day for up to 60 **lifetime reserve days**

Each lifetime reserve day may be used only once, but you may apply the days to different benefit periods.

Copays for skilled nursing facility stays are:

- \$0 for days 1–20
- \$167.50 per day for days 21–100

Lifetime reserve days may not be used to extend coverage in a skilled nursing facility.

Coinsurance

Home hospice patients may pay a small coinsurance amount for inpatient respite care so the patient's caregiver can rest or have time off.

Examples of Part A costs¹

Example 1: Short hospital stay

Julie had a 3-day stay in the hospital.

Julie's costs

| | |
|------------|---------|
| Deductible | \$1,340 |
|------------|---------|

| | |
|--------------------|-----|
| Copay for days 1–3 | \$0 |
|--------------------|-----|

| | |
|-------------------------|----------------|
| Total Julie pays | \$1,340 |
|-------------------------|----------------|

Example 2: Hospital stay and readmission in one benefit period

Roger had a 5-day stay, went home and was readmitted within 60 days for a 3-day stay. Both of Roger's hospital stays happened within one benefit period, so he paid just one deductible.

Roger's costs

| | |
|------------|---------|
| Deductible | \$1,340 |
|------------|---------|

First stay

| | |
|--------------------|-----|
| Copay for days 1–5 | \$0 |
|--------------------|-----|

Second stay

| | |
|--------------------|-----|
| Copay for days 6–8 | \$0 |
|--------------------|-----|

| | |
|-------------------------|----------------|
| Total Roger pays | \$1,340 |
|-------------------------|----------------|

Example 3: Hospital stay and readmission in two separate benefit periods

Margaret had a 5-day hospital stay in January, went home and was readmitted in September for a 65-day stay. Her second hospital stay starts a new benefit period so she must pay a second deductible.

Margaret's costs

First stay

| | |
|------------------------|---------|
| Deductible 1 (January) | \$1,340 |
|------------------------|---------|

| | |
|--------------------|-----|
| Copay for days 1–5 | \$0 |
|--------------------|-----|

Second stay

| | |
|--------------------------|---------|
| Deductible 2 (September) | \$1,340 |
|--------------------------|---------|

| | |
|---------------------|-----|
| Copay for days 1–60 | \$0 |
|---------------------|-----|

| | |
|---|---------|
| Copay for days 61–65 (5 days at \$335 each) | \$1,675 |
|---|---------|

| | |
|----------------------------|----------------|
| Total Margaret pays | \$4,355 |
|----------------------------|----------------|

Example 4: Long hospital stay

Juan stayed in the hospital for 185 days. His Part A benefits for the benefit period are used up after 150 days, including all his lifetime reserve days. The hospital charged \$1,200 per day for days 151–185.

Juan's costs

| | |
|------------|---------|
| Deductible | \$1,340 |
|------------|---------|

| | |
|---------------------|-----|
| Copay for days 0–60 | \$0 |
|---------------------|-----|

| | |
|--|----------|
| Copay for days 61–90 (30 days at \$335 each) | \$10,050 |
|--|----------|

| | |
|--|----------|
| Copay for days 91–150 (60 lifetime reserve days at \$670 each) | \$40,200 |
|--|----------|

| | |
|--|----------|
| Payment for days 151–185 (35 days at \$1,200 each) | \$42,000 |
|--|----------|

| | |
|------------------------|-----------------|
| Total Juan pays | \$93,590 |
|------------------------|-----------------|

¹Examples are for illustration and only hospital charges are shown. There may be additional costs for doctors and medical services. Costs shown are for 2018.

What you pay for Part B



Premium

The standard monthly Part B premium in 2018 is \$134.

You'll pay the standard amount if:

- You enroll for the first time in 2018.
- You aren't receiving Social Security benefits.
- Your premiums are billed directly to you.
- You have Medicare and Medicaid, and Medicaid pays your premiums.

Your premium may be less than the standard amount if you enrolled in Part B in 2017 or earlier and your premium payments are deducted from your Social Security check.

Your premium may be more than the standard amount based on your income. You will pay an income-related monthly adjustment amount (IRMAA) if your reported income from 2016 was above \$85,000 for individuals or \$170,000 for couples. Visit Medicare.gov to learn more about IRMAA.

Part B charges a penalty if you don't sign up when you are first eligible. The penalty is 10% of the monthly premium amount for each full 12-month period that you could have had Part B but didn't sign up for it. The penalty is added to your monthly premium payment for as long as you're enrolled in Part B.

You may avoid the penalty if you qualify for and sign up during a Special Enrollment Period. See page 34.

Deductible

The annual Part B deductible is \$183 in 2018.

Coinsurance

You generally pay 20% of the Medicare-approved amount for the covered services you use, with no annual out-of-pocket maximum. Medicare pays the remaining 80%.

Medicare-approved amount

Medicare decides how much providers should be paid for covered services. This is called the "Medicare-approved amount."

Doctors and other providers may **accept assignment** and take the Medicare-approved amount as payment in full, even if it's less than what they usually charge.

Doctors who do not accept assignment may charge more than the Medicare-approved amount and bill you for the difference. The additional amount they may bill, called "excess charges," is based on the following:

- Medicare reduces the Medicare-approved amount by 5%.
- Medicare pays 80% and you pay 20% of the reduced amount.
- The doctor may then charge you an additional amount, up to 15% of the reduced Medicare-approved amount.

Examples of Part B costs¹

Example 1: Doctor accepts Medicare assignment

Ellen's doctor agrees to take the Medicare-approved amount as full payment. Here is a breakout of Ellen's costs. She already paid her Part B deductible for the year.

Ellen's costs

| | |
|---|-------|
| Doctor fee | \$300 |
| Medicare-approved amount for these services | \$220 |
| Medicare pays 80% of \$220 | \$176 |

Ellen pays 20% coinsurance on \$220 **\$44**

Example 2: Doctor doesn't accept Medicare assignment

Ellen's doctor does not agree to take the Medicare-approved amount as full payment. Ellen is responsible for any additional charges. She already paid her Part B deductible for the year.

Ellen's costs

| | |
|---|-------|
| Doctor fee | \$300 |
| Medicare-approved amount for these services | \$220 |
| Medicare reduces the Medicare-approved amount by 5% | \$209 |
| Medicare pays 80% of \$209 | \$167 |

Ellen pays 20% coinsurance on \$209 **\$42**

Doctor charges additional 15% of the reduced Medicare-approved amount **\$31**

Ellen pays 20% coinsurance on \$209 plus excess charges **\$73**

¹Examples are for illustration only. Your costs may be different.

Medicare Part C: Medicare Advantage

Medicare Part C is Medicare Advantage. Medicare Advantage plans combine Part A and Part B benefits into one plan. Most include prescription drug coverage and offer additional benefits as well, often with no additional premium.

Medicare Advantage plans are offered by private insurance companies approved by Medicare. Coverage and costs beyond the standards set by Medicare may vary from plan to plan.



Combines Part A and Part B benefits into one plan

What Part C covers

All Medicare Advantage plans cover:

All the benefits of Part A (except hospice care, which is still covered by Part A)

All the benefits of Part B

Most Medicare Advantage plans cover:

Prescription drugs

Medicare Advantage plans may offer additional benefits, such as:

Dental exams, cleanings and X-rays

Eye exams, eyeglasses and corrective lenses

Hearing tests and hearing aids

Wellness programs and fitness membership

Plan types and service areas

Many Medicare Advantage plans are **coordinated care plans**. Plans contract with a network of doctors and hospitals to provide care to plan members. Plans may require members to choose a primary care doctor from the network to manage their care.

Each plan creates its own provider network. In most cases, you pay less for care you receive from network providers than for the same care received from providers outside the network.

Certain types of plans allow for more freedom in choosing providers, though it may come with a cost. All plans offer nationwide coverage for emergency care, urgent care and renal dialysis.

Medicare Advantage plans operate within defined geographic areas called **service areas**. You must live in a plan's **service area** to become a plan member.

Coordinated care plans

Health Maintenance Organization plans (HMO)

- Require you to seek care from providers in your network
- Do not cover any of the cost for care you receive outside the network, except for emergency care, urgent care and renal dialysis
- May require you to choose a primary care provider, who may then manage any care you receive from specialists
- May require you to get a referral from your primary care provider to see a specialist

Point of Service plans (POS)

- A type of HMO plan that allows you to see doctors and hospitals outside the plan network for some covered services, usually for a higher copayment or coinsurance
- May or may not require you to get a referral for specialty services

Preferred Provider Organization plans (PPO)

- Generally offer more freedom to choose doctors and other providers
- Don't require a referral to see a specialist
- Allow you to see providers outside the network, though you'll usually pay more than you would with a network provider

Special Needs Plans (SNP)

- Are designed for people with specific health care needs, including nursing home residents, those with chronic conditions and people who are eligible for both Medicare and Medicaid
- May provide care managers or nurse practitioners to help members get the care they need
- Usually have plan-specific eligibility requirements

Other plan types

Private Fee-For-Service plans (PFFS)

- Typically allow members to see any provider in the United States who accepts Medicare and the plan's payment terms and conditions
- Vary in their coverage and costs
- Don't require a referral to see a specialist

Medical Savings Account plans (MSA)

- Combine a high-deductible health plan with a special savings account
- Funds received from Medicare are deposited into the savings account and may be withdrawn tax free to pay qualified health care expenses
- Do not include prescription drug coverage

What you pay for Part C



Premium

- Medicare Advantage plans (Part C) may charge premiums, though some do not.
- Plan premiums vary widely and can change from year to year.
- You continue to pay your Part B premium and your Part A premium, if you have one, to Medicare.

Deductible

Some Medicare Advantage plans charge a deductible and others don't. Also, deductibles may be applied to drug benefits and not to medical benefits when a plan covers both. Deductible amounts may vary widely.

Copay

Many Medicare Advantage plans charge copays. You may pay a \$15 copay for a doctor visit or a \$10 copay for a prescription, for example. Copay amounts vary from plan to plan.

Coinsurance

Copays are more common, but Medicare Advantage plans may set coinsurance terms for some services.

Out-of-pocket maximum

Medicare Advantage plans are required to set an out-of-pocket maximum. An out-of-pocket maximum is the total amount you might pay for covered health care services during the plan period — usually a calendar year.

- Your plan pays all your covered costs for the rest of the plan period if you reach the out-of-pocket maximum.
- Premium payments, drug costs and the cost of extra services a plan may cover, such as vision or dental care, do not count toward the out-of-pocket maximum.
- Medicare places a limit on how high a plan can set its maximum. Plan maximums may be lower than the limit. The limit in 2018 is \$6,700.
- There is no out-of-pocket maximum with Original Medicare.

Examples of Part C costs¹

Example 1: In-network office visit

Michael goes to an in-network doctor for an office visit.

Michael's costs

| | |
|------------------------|------|
| Copay for office visit | \$15 |
|------------------------|------|

| | |
|---------------------------|-------------|
| Total Michael pays | \$15 |
|---------------------------|-------------|

Example 2: Brief hospital stay

Maria stays in the hospital for 3 days, goes home for a week and then spends 4 more days in the hospital. Her plan charges a \$150 copay for each day in the hospital.

Maria's costs

| | |
|-----------------------------------|-------|
| Copays for days 1-3 of first stay | \$450 |
|-----------------------------------|-------|

| | |
|------------------------------------|-------|
| Copays for days 1-4 of second stay | \$600 |
|------------------------------------|-------|

| | |
|-------------------------|----------------|
| Total Maria pays | \$1,050 |
|-------------------------|----------------|

Example 3: Long hospital stay

William stays in the hospital for 185 days. His plan charges a \$150 copay for each day in the hospital and has a \$3,000 maximum, or cap, on out-of-pocket spending.

William's costs

| | |
|---|---------|
| Copays for days 1-20 (20 days at \$150 per day) | \$3,000 |
|---|---------|

| | |
|---|-----|
| Copays for days 21-185 (after the cap is reached) | \$0 |
|---|-----|

| | |
|---------------------------|----------------|
| Total William pays | \$3,000 |
|---------------------------|----------------|



Compare plan prices

Medicare Advantage plan benefits and costs can vary widely, so be sure to shop around for a plan that works for you.

¹Examples are for illustration only. Your costs may be different.

Medicare Part D: Prescription drug coverage

You can get prescription drug coverage with a standalone Part D plan or with a Medicare Advantage plan that includes prescription drug coverage.



Helps pay for prescription drugs

What Part D covers

Medicare Part D plans cover:

Types of drugs most commonly prescribed for Medicare beneficiaries as determined by federal standards

Specific **brand name drugs** and **generic drugs** included in the plan's **formulary**, or list of drugs

What isn't covered by Part D

- Drugs not on the plan formulary
- Drugs prescribed for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs prescribed for erectile dysfunction
- Drugs used for cosmetic purposes or hair growth
- Prescription vitamins and mineral products
- Non-prescription drugs
- Drugs received while an inpatient (these may be covered by Part A)

What pharmacy can I use?

- Some plans have a network of pharmacies for you to choose from, while others offer nationwide coverage
- Plans may also offer mail order service

What is a formulary?

A formulary is a list of drugs covered by a plan. Medicare sets standards for the types of drugs Part D plans must cover, but each plan chooses the specific brand name and generic drugs on its formulary.

Many plans have a **tiered formulary** where drugs are divided into groups based on cost. In general, drugs on low tiers cost you less than drugs on high tiers.

Plans may charge a deductible for certain drug tiers and not for others, or the deductible amount may differ based on the tier.

Formulary Tiers

| | |
|--------|------------|
| Tier 1 | \$ |
| Tier 2 | \$\$ |
| Tier 3 | \$\$\$ |
| Tier 4 | \$\$\$\$ |
| Tier 5 | \$\$\$\$\$ |

Plans may add or remove specific drugs from their drug lists from year to year. Changes may also be made during the year under certain circumstances, such as if a drug is removed from the market. You will be notified if a change affects a drug you are taking.

Getting value from your plan

- **Know the formulary.** Make sure the medications you take are on the plan formulary. Check with your doctor to see if there's a covered drug you can switch to if needed.
- **Consider generics.** Ask your provider about generic or low-cost options if your drug is in a high tier or is too expensive.
- **Show your member ID card.** Be sure you take advantage of the discounted plan prices when you fill a prescription.
- **Use the mail order pharmacy.** You may get savings and convenience when you order 3-month supplies of your medications.
- **Use a network preferred pharmacy.** Save with low prices offered with many plans.



Step therapy

Plans may require step therapy for certain drugs. With step therapy, you must first try a low-cost drug that has been shown to be effective in treating your condition before the plan will cover a more expensive drug. If the low-cost drug doesn't work, you and your doctor can request approval from the plan to try the next-level treatment.

Drug coverage stages

Part D has four coverage stages:

- Annual deductible
- Initial coverage
- Coverage gap
- Catastrophic coverage

How your drug costs are set

Each plan negotiates prices with drug manufacturers and pharmacies. Your copays or coinsurance rates are based on your plan's negotiated prices and on guidelines set by Medicare.

The amount you pay for your drugs throughout the year also depends on the drug coverage stages you go through during the year. People who take few prescription drugs may remain in the deductible stage or move only to the initial coverage stage. People who take many medications or whose medications are expensive may move into the **coverage gap** or **catastrophic coverage stage** during the year.

The coverage stage cycle starts over at the beginning of each plan year, usually on January 1.

Individual Part D plans explain specific drug costs in their Summary of Benefits or Evidence of Coverage materials.

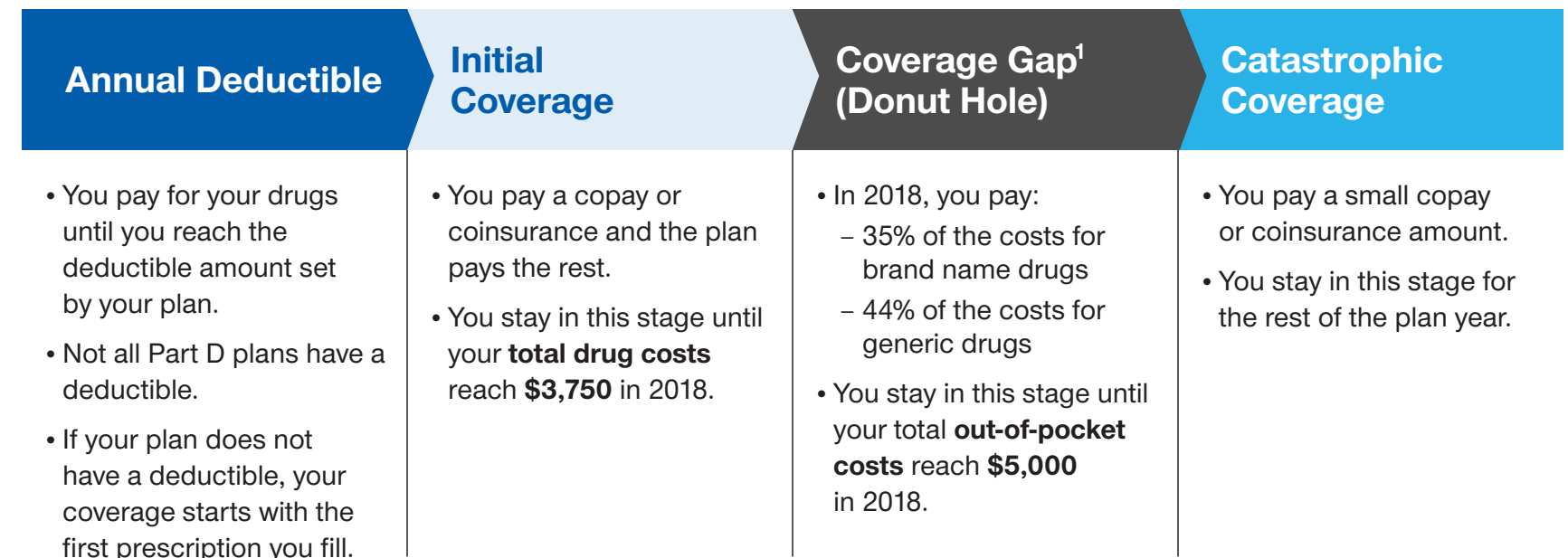
The Part D coverage gap

The Part D coverage gap, or donut hole, opens when you and your plan have paid up to a set limit for your drugs in one year. You pay a bigger share of the cost for your drugs while you're in the coverage gap than you did up to that point.

You exit the coverage gap when the amount paid for your drugs reaches another set limit.

Medicare sets the spending limits for each year, as well as what counts toward reaching the limits.

The coverage gap is shrinking. Those who enter it are paying a smaller percentage of the cost for their drugs each year. By 2020 Medicare beneficiaries will pay 25% of the cost for both brand name and generic drugs.

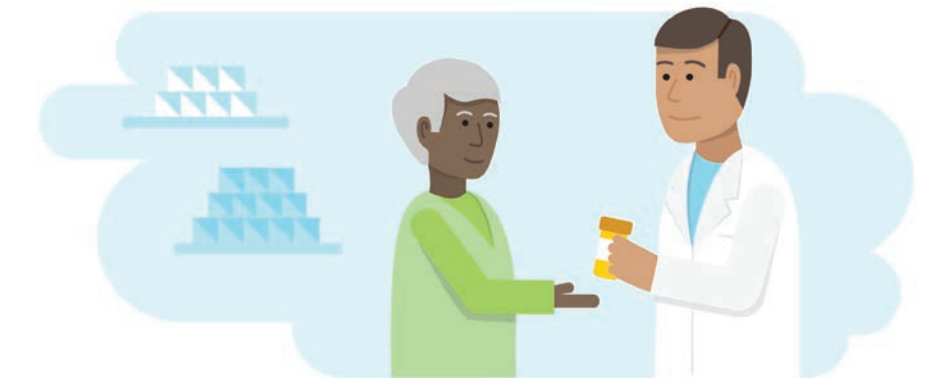


Total drug costs

The amount you (or others on your behalf) and your plan pay for your prescription drugs. Your plan premium payments are not included in this amount.

Out-of-pocket costs

The amount you (or others on your behalf) pay for your prescription drugs plus the standard 50% discount on your brand name drugs provided by drug manufacturers. Your plan premium payments are not included in this amount.



¹If you get Extra Help from Medicare, the coverage gap doesn't apply to you.

What you pay for Part D



Premium

Standalone Part D plans charge a premium, and each plan sets the amount it charges. Medicare Advantage plans with drug coverage generally charge one premium for all benefits — medical, hospital and prescription drugs.

Deductible

Some plans charge a deductible and others do not. Plans may also have a deductible for drugs in certain formulary tiers and not for others. Deductible amounts could also vary from one drug tier to another.

Medicare sets a maximum deductible amount each year. The maximum annual deductible a Part D plan may charge in 2018 is \$405.

Copay

A copay is generally required each time you fill a prescription for a covered drug. Copay amounts usually vary based on a plan's formulary tiers, with low-tier drugs costing less. Copay amounts may also vary depending on which pharmacy you use.

Each plan sets its own copay terms and amounts, and these can vary widely from plan to plan.

Coinsurance

Copays are more common, but some plans may set coinsurance rates for certain drugs or drug tiers.

You may qualify for Extra Help

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. To see if you qualify for Extra Help, call:

- Medicare at **1-800-MEDICARE (1-800-633-4227)**, TTY **1-877-486-2048**, 24 hours a day, 7 days a week
- The Social Security Administration at **1-800-772-1213**, TTY **1-800-325-0778**
- Your state Medicaid office

Examples of Part D costs¹

Example 1: Moderate prescription drug spending

Helen spends \$100 a month for two drugs. She enrolls in a Medicare Advantage plan with built-in Part D drug coverage. Helen's plan premium is \$32 a month with no deductible. Helen only reaches the initial coverage stage.

Helen's cost with no drug coverage

| | |
|---------------------|----------------|
| (\$100 x 12 months) | \$1,200 |
|---------------------|----------------|

Helen's costs with drug coverage

| | |
|---|-------|
| Annual premium for Medicare Advantage plan (\$32 x 12 months) | \$384 |
|---|-------|

Initial coverage stage

| | |
|---------------|-------|
| Helen's share | \$250 |
|---------------|-------|

Coverage gap stage

| | |
|--|-----|
| | N/A |
|--|-----|

Catastrophic coverage stage

| | |
|--|-----|
| | N/A |
|--|-----|

| | |
|-------------------------------|--------------|
| Total Helen pays for the year | \$634 |
|-------------------------------|--------------|

| | |
|--|--------------|
| Helen's annual savings with drug coverage | \$566 |
|--|--------------|

Example 2: Heavy prescription drug spending

Enrico has several chronic conditions. His drugs cost \$950 a month. Enrico has Original Medicare (Part A and Part B) plus a standalone Medicare Part D drug plan. His plan premium is \$32 a month with no deductible. Enrico goes through all the coverage stages.

Enrico's cost with no drug coverage

| | |
|---------------------|-----------------|
| (\$950 x 12 months) | \$11,400 |
|---------------------|-----------------|

Enrico's costs with drug coverage

| | |
|--|-------|
| Annual premium for Part D drug plan (\$32 x 12 months) | \$384 |
|--|-------|

Initial coverage stage

| | |
|----------------|-------|
| Enrico's share | \$720 |
|----------------|-------|

Coverage gap stage

| | |
|--|---------|
| Enrico's additional cost sharing up to the limit | \$4,280 |
|--|---------|

Catastrophic coverage stage

| | |
|----------------|-------|
| Enrico's share | \$236 |
|----------------|-------|

| | |
|--------------------------------|----------------|
| Total Enrico pays for the year | \$5,620 |
|--------------------------------|----------------|

| | |
|---|----------------|
| Enrico's annual savings with drug coverage | \$5,780 |
|---|----------------|

¹Examples are for illustration only. Your costs may be different.

Medicare supplement insurance: Medigap

Medicare supplement insurance, or Medigap, is private insurance that helps pay for some of the out-of-pocket costs not paid by Original Medicare (Part A and Part B).

There are ten plans standardized by the federal government. Each is labeled with a letter. All plans with the same letter offer the same benefits. Massachusetts, Minnesota and Wisconsin have different plans.



Helps pay some costs not paid by Original Medicare

What Medicare supplement insurance covers

Medicare supplement insurance helps with:

Part A and Part B deductibles

Copays and coinsurance

Provider excess charges

An additional 365 days of hospital care during your lifetime, beyond your Medicare lifetime reserve days

Blood transfusions (first 3 pints)

Foreign travel emergencies

What isn't covered by Medicare supplement insurance

- Long-term care
- Routine eye exams or eyeglasses
- Routine hearing test or hearing aids
- Routine dental exams, cleaning or X-rays
- Private duty nursing
- Days in a skilled nursing facility beyond the 100 days covered by Part A

Types of Medicare supplement insurance plans

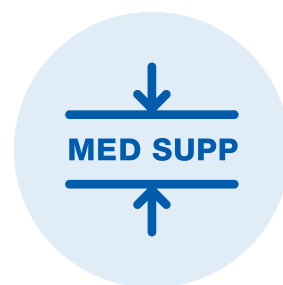
| Benefits Covered | Plan A | Plan B | Plan C | Plan D | Plan F ¹ | Plan G | Plan K | Plan L | Plan M | Plan N |
|--|--------|--------|--------|--------|---------------------|--------|------------------------|------------------------|----------------|---|
| Part A hospital coinsurance and 365 extra hospital days | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Part A deductible | | 100% | 100% | 100% | 100% | 100% | 50%² | 75%² | 50% | 100% |
| Part B coinsurance or copays | 100% | 100% | 100% | 100% | 100% | 100% | 50%² | 75%² | 100% | 100% except certain copays³ |
| Part B annual deductible | | | 100% | | 100% | | | | | |
| Part B excess charges | | | | | 100% | 100% | | | | |
| Cost of blood transfusion (first 3 pints) | 100% | 100% | 100% | 100% | 100% | 100% | 50%² | 75%² | 100% | 100% |
| Cost of foreign travel emergency (up to the plan limits) | | | 80% | 80% | 80% | 80% | | | 80% | 80% |
| Hospice care coinsurance cost | 100% | 100% | 100% | 100% | 100% | 100% | 50%² | 75%² | 100% | 100% |
| Part B preventive care coinsurance | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Skilled nursing facility care coinsurance | | | 100% | 100% | 100% | 100% | 50%² | 75%² | 100% | 100% |
| Yearly out-of-pocket limit before 50%/75% benefits paid at 100% (2018) | | | | | | | | \$5,240 | \$2,620 | |

¹Plan F also comes in a high-deductible version, under which you must pay the cost for covered services up to the deductible amount of \$2,240 in 2018 before your Medicare supplement plan starts paying.

²100% after you reach your yearly out-of-pocket limit.

³Up to \$20 copay for doctor visits and up to \$50 copay for ER visits.

What you pay for Medicare supplement insurance



Premium

Plans set their own premiums. As a general rule, the more generous the coverage, the higher the premium.

Premiums vary widely from insurer to insurer even if they offer the exact same coverage. Plans may change their premiums from year to year.

Plans pay different costs

The level of coverage and what you pay varies by plan. Some plans split certain costs with you up to a set limit. Others leave certain costs, like the Part B deductible or select copays, for you to pay on your own.

The chart on page 29 shows the out-of-pocket costs that each standard Medicare supplement plan will pay.

Comparing plans

Four people have the same health care experience:

- 15 days in the hospital
- 22 days in a skilled nursing facility
- Two follow-up doctor visits (doctor does not accept assignment)

Ned has Original Medicare (Parts A and B) and no Medicare supplement plan. Allan, Carlos and Frank also have Original Medicare, and each has a different supplement plan. All of them have met their Part B deductibles for the year.

The examples on the next page show the cost difference for each person based on his plan.

Examples of Medicare supplement insurance coverage¹

Ned's costs: Original Medicare (without Medicare supplement insurance)

| | |
|--|----------------|
| Part A deductible | \$1,340 |
| Part A copay for skilled nursing facility over 20 days (2 days x \$167.50) | \$335 |
| Part B coinsurance for two doctor visits (20% of Medicare-approved amount) | \$32 |
| Part B excess charges (see page 17) for the same two doctor visits (15% of Medicare-approved amount) | \$24 |
| With no Medicare supplement plan, Ned pays | \$1,731 |

Allan's costs: Original Medicare with Medicare supplement Plan A

| | |
|--|----------------|
| Without a Medicare supplement insurance plan Allan would pay | \$1,731 |
| Plan A pays | |
| Part B copay for two doctor visits | -\$32 |
| With Plan A, Allan pays | \$1,699 |

Carlos' costs: Original Medicare with Medicare supplement Plan C

| | |
|--|-------------|
| Without a Medicare supplement insurance plan Carlos would pay | \$1,731 |
| Plan C pays | |
| Part A deductible | -\$1,340 |
| Part A copay for 2 days in a skilled nursing facility (\$167.50/day) | -\$335 |
| Part B coinsurance for two doctor visits | -\$32 |
| With Plan C, Carlos pays | \$24 |

Frank's costs: Original Medicare with Medicare supplement Plan F

| | |
|---|------------|
| Without a Medicare supplement insurance plan Frank would pay | \$1,731 |
| Plan F pays | |
| Part A deductible | -\$1,340 |
| Part A copay for 2 days in a skilled nursing facility (\$167.50/day) | -\$335 |
| Part B coinsurance for two doctor visits | -\$32 |
| Part B excess charges for doctor visits (15% over Medicare-approved amount) | -\$24 |
| With Plan F, Frank pays | \$0 |

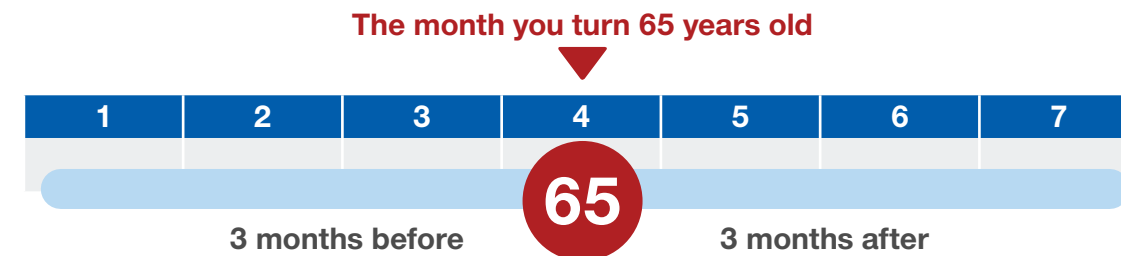
¹Examples are for illustration only. Your costs may be different.

When to enroll

Initial Enrollment Period

Your Initial Enrollment Period (IEP) is 7 months long. It includes your birthday month plus the 3 months before and the 3 months after. Your IEP begins and ends one month earlier if your birthday is on the first of the month. If you become eligible for Medicare due to disability, your 7-month IEP includes the month you receive your 25th disability check plus the 3 months before and the 3 months after.

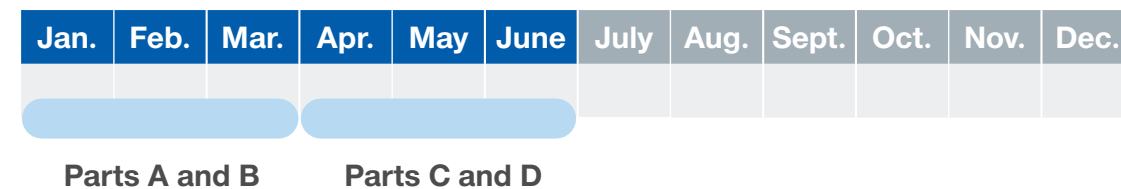
You may enroll in Part A, Part B or both. If you enroll in both Part A and Part B, you may choose to join a Medicare Advantage plan (Part C) or a prescription drug plan (Part D). You may also join a Part D plan if you enroll in just Part B.



General Enrollment Period

The General Enrollment Period (GEP) is when those who missed their IEP can enroll in Medicare Part A, Part B or both. The GEP happens every year from January 1 to March 31. You may enroll in a Medicare Advantage plan (Part C) or a prescription drug plan (Part D) from April 1 to June 30 the same year, if you enroll in both Part A and Part B during a GEP. You may also enroll in a Part D plan if you enroll only in Part B during a GEP.

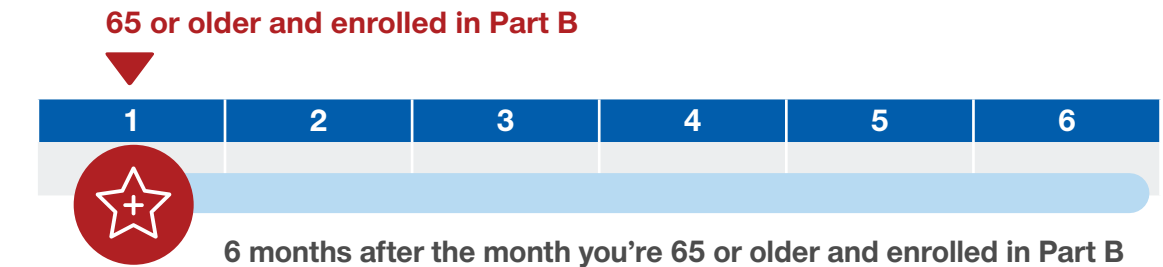
Every year



Medicare Supplement Open Enrollment

Your Medicare supplement open enrollment is 6 months long. It begins the month you are 65 or older and are enrolled in Medicare Part B. You cannot be denied coverage if you enroll during your open enrollment.

You may apply for Medicare supplement insurance after your open enrollment ends, but you could be denied or charged a higher premium based on your health history. Some states may allow for additional Open Enrollment Periods.



Enrollment tip

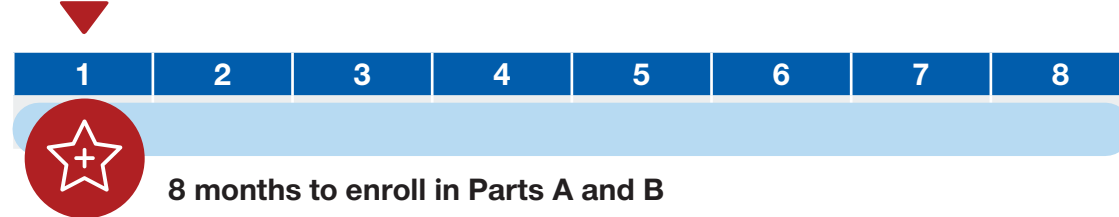
Enrollment in Medicare Part A and Part B is automatic if you already get Social Security benefits or become eligible for Medicare due to disability. If you're not enrolled automatically, you can enroll yourself. Go to [SSA.gov/Medicare](https://www.ssa.gov/Medicare) to enroll online, or call or visit your local Social Security office.

When to enroll

Special Enrollment Period: Working past 65

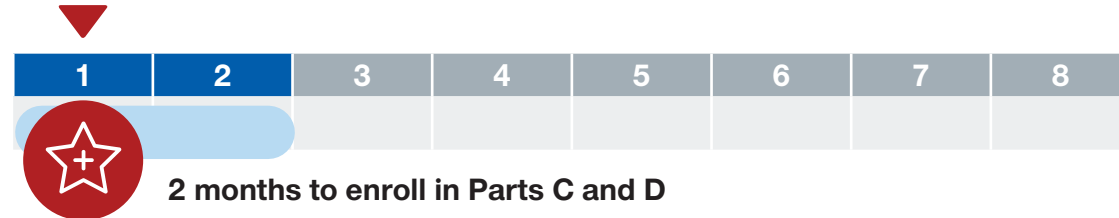
You may qualify for a Special Enrollment Period to enroll in Part A, Part B or both without penalty for up to 8 months after the month your employment or employer coverage ends, whichever comes first. This is also true if you are covered under your spouse's employer coverage. You must be 65 to be eligible for Medicare.

Month after the last month of employment or employee health coverage



You can also enroll in a Medicare Advantage plan (Part C) or prescription drug plan (Part D) up to 2 full months after the month your employment or employer health insurance ends. You must be enrolled in Part B to be eligible for a Medicare Advantage plan.

Month after the last month of employment or employee health coverage



Late enrollment penalties

Medicare Part A, Part B and Part D may charge premium penalties if you enroll late. Medicare supplement plans may also penalize late enrollment. Make sure you know your enrollment period dates and what your options are. You may delay enrolling without incurring penalties in certain situations.



Medicare Part A

Most people don't pay a premium for Part A, but those who do may be penalized if they sign up after their IEP. The penalty is an additional 10% of the premium amount. It's charged every month for twice the number of years enrollment was delayed.

Medicare Part B

Part B charges a penalty when you enroll after your IEP, unless you qualify for a Special Enrollment Period. The penalty is an additional 10% of the premium amount for each full 12-month period enrollment is delayed. It's charged every month for as long as you have Part B.

Medicare Part D

The penalty for late enrollment in a Part D plan is 1% of the average Part D premium for each month you delay enrollment. You pay the penalty for as long as you're enrolled in a Medicare Part D plan. You may delay enrolling in Medicare Part D without penalty if you qualify for Extra Help or have creditable drug coverage.

Medicare supplement insurance

You may apply for Medicare supplement insurance any time, even after your Open Enrollment Period. But you could be denied coverage or charged a higher premium based on your health history.

When you can make a change

Medicare Open Enrollment

Medicare Open Enrollment is October 15 to December 7 every year. During this time, you can join, switch or drop a Medicare Advantage plan or a prescription drug plan.

You will automatically go back to Original Medicare if you drop a Medicare Advantage plan, and you will lose drug coverage if it was included with your plan. You may replace it with a standalone prescription drug plan at this time without penalty. A penalty may apply if you drop drug coverage and decide to get it again later.

Every year

| Jan. | Feb. | Mar. | Apr. | May | June | July | Aug. | Sept. | Oct. | Nov. | Dec. |
|------|------|------|------|-----|------|------|------|-------|------|------|------|
| | | | | | | | | | | | |

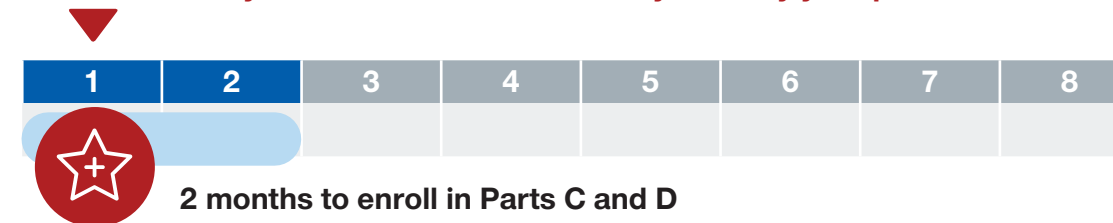
October 15 – December 7



Special Enrollment Periods

A Special Enrollment Period (SEP) allows you to join, change or drop a Medicare Advantage plan or prescription drug plan outside of Medicare Open Enrollment in certain situations, such as when you move. These situations are called “qualifying events.” In most cases, you have 2 full months after the month of a qualifying event to make plan changes.

Month after you move or the month after you notify your plan



Medicare Advantage Disenrollment Period

This period is January 1 to February 14 every year. You may switch from a Medicare Advantage plan to Original Medicare during this time. You may also enroll in a Part D prescription drug plan. You may have to pay a penalty if you wait to enroll in a Part D plan at a later time.

Every year

| Jan. | Feb. | Mar. | Apr. | May | June | July | Aug. | Sept. | Oct. | Nov. | Dec. |
|------|------|------|------|-----|------|------|------|-------|------|------|------|
| | | | | | | | | | | | |

January 1 – February 14



Coverage combinations

Medicare isn't one-size-fits-all. You can combine different Medicare parts and plans to get the coverage you want.




There are seven possible combinations.

Note





Combination number 7 is available only if you choose a Private Fee-For-Service (PFFS) Medicare Advantage plan without drug coverage or a Medicare Medical Savings Account (MSA) plan. These are the only types of Medicare Advantage plans that can be combined with a standalone Medicare prescription drug plan.

- 1**  




Original Medicare (Parts A and B) or just Part A or just Part B

- 2**   + 



Original Medicare (Parts A and B) **plus** a standalone Part D plan

- 3**   +  + 


Original Medicare (Parts A and B) **plus** a standalone Part D plan **plus** a Medicare supplement plan

- 4**   + 



Original Medicare (Parts A and B) **plus** a Medicare supplement plan

- 5**  

A Medicare Advantage (Part C) plan with built-in drug coverage









- 6** 

A Medicare Advantage (Part C) plan without drug coverage

- 7**  + 

A Medicare Advantage (Part C) plan without drug coverage **plus** a standalone Part D plan

Medicare supplement or Medicare Advantage?

| |  Medicare supplement insurance plans |  Medicare Advantage plans |
|---|--|---|
|  Doctors and hospitals | You can select your doctors and hospitals as long as they accept Medicare patients. | You may be required to use doctors and hospitals in the plan network. |
|  Referrals | You can see specialists without referrals. | You may need referrals and may be required to use network specialists, depending on the plan. |
|  Network | No network restrictions with most plans. Coverage goes with you when you travel in the United States. | You may have network restrictions. Emergency care is covered for travel within the United States and sometimes abroad. |
|  Enrollment | You can apply to buy a plan any time after you turn 65. However, during your Open Enrollment Period you are guaranteed coverage at the best available rate regardless of your health status. | Generally, there are specific periods during the year when you can enroll or switch to a different Medicare Advantage plan. You can't be denied coverage or charged more based on your health status. |
|  Costs | You pay a monthly plan premium in addition to your Part B premium. When you use services, your out-of-pocket costs are limited. | Generally, you pay a low or \$0 monthly plan premium in addition to your Part B premium. When you use services, you pay copays, coinsurance and deductibles up to a set out-of-pocket limit. |
|  Prescription drug coverage | Prescription drug coverage is not included. Consider adding a Part D plan. | Prescription drug coverage is included with most plans. |

Medicare coverage examples

When it comes to Medicare, different people have different needs. Here are a few examples of how people chose different Medicare plans based on their unique needs. The costs are shown for illustration. Your costs may be different.

Meet David

David just turned 65 and is already retired. He's in good shape and generally healthy. He takes a daily prescription drug to keep his high blood pressure in check. The drug currently costs him about \$90 each month. David takes good care of himself. He is careful to live within his budget.

David's wish list

- Access to a full range of health care services, including preventive care
- Coverage that provides a safety net in case of a serious illness
- Access to specialists if he needs them — he's comfortable with sticking to choices in a plan's network
- Access to prescription drug coverage in case he needs additional medications in the future

David's choice

- Medicare Advantage plan with built-in prescription drug coverage

Plan features

- Preventive care
- Fitness program at no additional cost
- Built-in prescription drug benefit
- Network of local doctors and hospitals

David's premiums

| | |
|-------------------------------|-------|
| Monthly Part B premium (2018) | \$134 |
|-------------------------------|-------|

| | |
|---|------|
| Monthly Medicare Advantage plan premium (includes prescription drug coverage) | \$34 |
|---|------|

| | |
|----------------------|--------------|
| Monthly total | \$168 |
|----------------------|--------------|

Cost sharing: David may have other out-of-pocket costs based on the specific cost-sharing terms of his plan. His total spending will depend on the health care services he uses and the prescriptions he fills. His plan caps David's out-of-pocket spending at \$3,500 per year.

Meet Juanita

Juanita will be 65 in 3 months. She plans to retire then and spend a lot of time out of state visiting her children and grandchildren in California. Juanita is in good health, although she takes a drug to keep her bones strong, plus another drug to keep her cholesterol down. Juanita has a comfortable pension, but she wants to leave a financial legacy to her family.

Juanita's wish list

- Access to doctors and hospitals when she's out of state visiting her children
- Help with paying for her prescription drugs
- Peace of mind of knowing that she will have help paying her health care costs if they are high

Juanita's choice

- Original Medicare (Parts A and B)
- Standalone Medicare prescription drug plan (Part D)
- Medicare supplement insurance plan (Plan F)

Plan features

- Access to doctors and hospitals throughout the United States
- Discounted prices on the drugs she takes
- Help with costs not paid by Original Medicare

Juanita's premiums

| | |
|-------------------------------|-------|
| Monthly Part B premium (2018) | \$134 |
|-------------------------------|-------|

| | |
|--|------|
| Monthly Medicare Part D prescription drug plan premium | \$32 |
|--|------|

| | |
|--|-------|
| Monthly Medicare supplement Plan F premium | \$150 |
|--|-------|

| | |
|----------------------|--------------|
| Monthly total | \$316 |
|----------------------|--------------|

Cost sharing: Juanita's Medicare supplement insurance plan covers most of her out-of-pocket costs with Original Medicare, but she must pay any that aren't. She also covers cost sharing associated with her drug plan.

Meet Georgia

Georgia will be 65 next month.

She has been working part-time since her husband died 5 years ago, but her income is limited. Georgia has heart disease, so she sees a heart specialist regularly and takes a blood-thinning medicine every day. She cannot afford a Medicare supplement policy.

Georgia's wish list

- Health care at an affordable price
- Access to her trusted doctors
- Discounted prices on her prescription drugs
- The possibility of help with her premiums and cost sharing if she qualifies for low-income assistance

Georgia's choice

- Original Medicare (Parts A and B)
- Standalone Medicare prescription drug plan (Part D)

Plan features

- Access to the doctors and hospitals she uses now
- Discounted prices on the drugs she takes

| Georgia's premiums | |
|--|--------------|
| Monthly Part B premium (2018) | \$134 |
| Monthly Medicare Part D prescription drug plan premium | \$32 |
| Monthly total | \$166 |

Other cost sharing: Georgia pays drug plan cost sharing and all costs not covered by Original Medicare. If Georgia qualifies for financial help, her cost sharing could be significantly lower.



Meet Leroy

Leroy is about to turn 65. He has had serious health problems for years. He suffers from diabetes and high blood pressure, and his doctor has told him he needs to lose a considerable amount of weight. Leroy takes insulin and blood pressure medication every day. He has had trouble in the past with interactions of the drugs he is taking.

Leroy's wish list

- Expert help with managing his health problems
- Help with improving his diet, exercise and weight management
- Discounted prices on prescription drugs

Leroy's choice

- Medicare Advantage Special Needs Plan (SNP) for people with diabetes, with built-in prescription drug coverage

Plan features

- Access to a care manager who will create a plan for coordinating his care
- Help with finding out if he qualifies for financial assistance with Medicare costs
- Discounted prices on the drugs he takes
- Help with adopting a healthier lifestyle

| Leroy's premiums | |
|---|--------------|
| Monthly Part B premium (2018) | \$134 |
| Monthly Medicare Advantage Special Needs Plan premium | \$24 |
| Monthly total | \$158 |

Other cost sharing: Leroy pays his cost sharing as determined by the plan. His total spending depends on the health care services he uses and the medications he takes.

Frequently asked questions

We want to help you by answering some of the most common questions about Medicare. These include questions about costs, Medicare Advantage plans, enrollment and coverage.

Q I'm turning 65 and have researched the Medicare choices in my area. I can't afford any of them, not even the Part B premiums. Where can I get help?

A You may qualify for financial help with Medicare premiums and other costs, like deductibles and copays. Contact your local Social Security Administration office or state Medical Assistance (Medicaid) program to find out if you qualify. See pages 9 and 52 for more information.

Q What happens if I join a Medicare Advantage plan and then move? Can I take my plan with me?

A If you stay within your current plan's service area, you can keep your plan. If you move out of your plan's service area, you may qualify for a Special Enrollment Period and enroll in a new plan. You could choose a new Medicare Advantage plan available in the area you're moving to, or you could return to Original Medicare (Part A and Part B), with the option of adding a prescription drug plan (Part D), a Medicare supplement plan or both.

To find out what your current plan's service area is, call the plan's customer service department or review your plan's evidence of coverage document.

Q What happens if I join a Medicare Advantage plan that uses a network of doctors and hospitals and my doctor leaves the network?

A Your Medicare Advantage plan will notify you if your doctor leaves the plan network and you will be able to choose a new doctor. Generally, you aren't able to change plans in this situation until the next Medicare Open Enrollment (unless you qualify for an exception).

Q I'm looking at a Medicare Advantage plan, but I don't know if my doctors are in the plan's network. How can I find out?

A Call the plan's customer service number and ask whether your doctors participate in the plan. You can also call your doctor's office and ask whether they accept the plan.

Q My spouse is turning 65 this year, retiring and planning to join Medicare. I'm 61, not working and have always used my spouse's health care benefits. What happens to me when my spouse joins Medicare?

A Medicare won't cover you until you reach age 65, even if your spouse is already receiving benefits. When your spouse joins Medicare, you will need to find other health insurance coverage until you turn 65.

Find out whether your spouse's current health coverage can cover you after your spouse retires. For example, you may be eligible for COBRA coverage for up to 36 months. Also, look for health insurance offered by groups you belong to, such as social or professional organizations or an alumni association. You may also be able to purchase an individual health insurance policy.

Q I have health care coverage now. What happens to that when I retire? I plan to retire as soon as I turn 65.

A Talk to someone who's familiar with the coverage you have now. That may be a benefits manager at your job or a union representative. If you have individual insurance you've been buying yourself, call customer service at the insurance company.

If you learn that you can keep your coverage, find out if it can be combined with Medicare coverage and what the costs might be.

Q Right now I have Original Medicare plus a Medicare supplement plan. If I join a Medicare Advantage plan, what do I do with my Medicare supplement plan? If I drop it, can I get it back?

A After you join a Medicare Advantage plan, you can keep your Medicare supplement plan, but you may not get much benefit from it and you'll have to keep paying for the premium. You can't use your Medicare supplement plan to pay for deductibles, copays and coinsurance under a Medicare Advantage plan. A Medicare supplement plan can only help with those payments under Original Medicare.

If you drop your Medicare supplement plan, you can apply for another one later if you want to. Because you will be buying a new plan, however, you can be charged a higher premium or refused entirely based on your health history. There are certain limited situations in which you have the right to buy a plan regardless of your health.

Medicare supplement plans are private insurance plans. Rules about buying Medicare supplement plans may vary by state. You may contact your State Health Insurance Assistance Program for help. See page 50.

Q I already have Medicare. How do I know what kind of Medicare coverage I have?

A The insurance card(s) you use when you go to the doctor or a hospital can help you figure out what kind of coverage you have.

You probably have Original Medicare if you use the Medicare card you received from the federal government to show that you have Medicare health insurance.

You probably have a Medicare Advantage plan if you use a card issued by a private insurance company to help pay for your health care services. If you use the same card to pay for your prescription drugs, your plan probably has prescription drug coverage.

You probably have a Part D prescription drug plan if you use a separate card to pay for your prescription drugs. If you have a discount card for prescription drugs, that doesn't mean you have a Part D plan.

You probably have a Medicare supplement plan if you have a separate card to help pay for some of the out-of-pocket costs you have with Original Medicare.

Glossary

Accept assignment

Doctors and other providers who accept assignment agree to take the Medicare-approved amount as full payment for their services. You may be charged a share of the cost. *See page 17.*

Benefit period

Under Medicare Part A, a “benefit period” is a period of time that begins when you are admitted to a hospital for an overnight stay and ends when you have been out of the hospital for 60 days in a row. *See page 14.*

Brand name drug

A prescription drug that is sold under a trademarked name. *See page 22.*

Catastrophic coverage

A Medicare Part D payment stage. In this stage, you pay a small copay or coinsurance rate for your prescription drugs and your plan pays the rest for the rest of the plan period, usually a calendar year. *See pages 24–25.*

Centers for Medicare & Medicaid Services (CMS)

The federal government agency that runs the Medicare program and works with the states to manage their Medicaid programs.

Coinsurance

A percentage of the cost for a health care service that you pay when you receive it. For example, you might pay 20% of the total allowed cost a doctor visit and Medicare or your Medicare plan would pay the remaining 80%. *See page 8.*

Coordinated care plan

A type of Medicare Advantage plan in which your care is coordinated by your primary care provider (PCP). These plans are also referred to as “managed care” plans. *See page 18.*

Copayment

The fixed amount you pay at the time you receive a covered service. For example, you might pay \$20 when you visit the doctor or \$12 when you fill a prescription. Also known as a “copay.” *See page 8.*

Coverage gap

A Medicare Part D payment stage. In this stage you pay most of the plan’s discounted cost for your covered medications. The coverage gap is also known as the “donut hole.” *See pages 24–25.*

Creditable drug coverage

Prescription drug coverage that provides coverage at least as good as Medicare Part D. You may delay enrolling in Part D without penalty if you have creditable drug coverage.

Custodial care

Care that provides help with daily living activities, such as eating, bathing and getting dressed. *See page 12.*

Deductible

A set amount you pay out of pocket for covered services before Medicare, your Medicare plan, or both, begins to pay. *See page 8.*

Dual eligible

A person who qualifies for both Medicare and Medicaid.

Extra Help

A program that helps eligible people pay for some or all of their Medicare Part D premiums, deductibles and copays. *See page 9.*

Formulary

A list of covered prescription drugs. Each plan decides what drugs will be on its formulary. *See page 23.*

Generic drug

A type of prescription drug that doesn’t have a trademarked name but has the same active ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs. *See page 22.*

Group retiree health coverage

Offered by some former employers, unions or trusts to provide their

Medicare-eligible retirees additional health and/or drug coverage as part of their retiree benefit package.

Guaranteed renewable policy

A feature of all Medicare supplement plans that guarantees that you can keep the plan each year as long as you pay your premium and don’t commit fraud against the insurance company.

Health Maintenance Organization plan (HMO)

A type of Medicare Advantage plan that provides care through a network of doctors and hospitals. If you get care outside the network, you will be responsible for the cost of your care in most cases. Exceptions include emergency care, urgent care and renal dialysis. *See page 19.*

Home health care

Skilled nursing care and therapy provided to those who are homebound on a part-time or intermittent basis.

Hospice care

Care provided to those who are terminally ill. Hospice care typically focuses on controlling symptoms and managing pain. *See page 12.*

Initial Enrollment Period (IEP)

A 7-month time period when you first become eligible and may sign up for Medicare. *See page 32.*

Inpatient care

Care that you receive after you are admitted to a hospital or skilled nursing facility for an inpatient stay. *See page 12.*

Late enrollment penalty

The additional amount added to your premium if you enroll outside of set enrollment periods. Parts A, B and D may charge late enrollment penalties. *See page 35.*

Lifetime reserve days

An additional 60 days of inpatient care that Medicare Part A will cover if you are in the hospital longer than 90 days in one benefit period. Each lifetime reserve day may be used only once. Days may be applied to different benefit periods. *See page 14.*

Medicaid

A joint federal and state program that helps pay health care costs for individuals and families with low incomes and few assets. *See page 9.*

Medical Savings Account plan

A type of Medicare Advantage plan that combines a high-deductible health plan with a self-directed bank savings account. Funds in the account may be used tax free to pay qualified medical expenses. *See page 19.*

Medically necessary care

Health care services or supplies that Medicare considers necessary to treat a medical condition.

Medicare

A federal health insurance program for U.S. citizens and legal residents 65 or older and others under 65 with a qualifying disability or medical condition. *See page 4.*

Medicare Advantage Disenrollment Period

A yearly time period, January 1 to February 14, during which you may drop a Medicare Advantage plan and return to Original Medicare. *See page 37.*

Medicare Advantage plan (Part C)

A private insurance plan that provides Medicare Part A and Part B benefits plus additional coverage. Plans are offered by Medicare-approved insurance companies as an alternative to Original Medicare. *See page 18.*

Medicare-approved amount

The amount Medicare will pay for a covered medical service. *See also: accept assignment.*

Medicare Open Enrollment

The period of time from October 15 to December 7 each year when you may join, drop or switch a Medicare Advantage plan or Medicare Part D prescription drug plan. *See page 36.*

Medicare Savings Programs

Federal financial assistance programs that help eligible people pay some or all of their Medicare premiums and deductibles. *See page 9.*

Medicare supplement insurance plan

A type of insurance that helps pay for some of the out-of-pocket costs not paid by Original Medicare. Plans are sold by private insurance companies. Also called Medigap. *See page 28.*

Medicare supplement open enrollment

The first 6 months you are enrolled in Medicare Part B at age 65 or older. During this time you do not have to answer medical questions and cannot be denied coverage or charged a higher premium due to health problems. (Insurance companies will also require you to be enrolled in Part A to get a Medicare supplement plan.)

Network

A group of health care providers, such as doctors, hospitals or pharmacies, that agree to provide care to members of a certain health care plan at agreed-upon rates.

Out-of-pocket maximum

The most you could pay during a plan period (usually a year) for covered health care services, if you have a Medicare Advantage plan. This amount does not include premium payments, prescription drug costs or the cost of extra services offered by your plan, such as vision or dental services. *See page 20.*

Outpatient care

Care provided to a patient who is not admitted to a hospital or skilled nursing facility. *See page 13.*

PACE

An acronym for Program of All-Inclusive Care for the Elderly. PACE provides medical, social and long-term care services to help frail older adults live in their communities rather than in nursing homes or other long-term care facilities.

Part A

The part of Original Medicare that helps pay for the cost of hospital stays, skilled nursing services following a hospital stay and some other kinds of skilled care. *See pages 12, 14–15.*

Part B

The part of Original Medicare that helps pay for the cost of doctor visits and other medical services that don't involve overnight hospital stays. *See pages 13, 16–17.*

Part C

The part of Medicare that combines Part A and Part B coverage in a single private health plan. Also called Medicare Advantage. *See page 18.*

Part D

The part of Medicare that helps pay for the cost of prescription drugs. You can get Medicare Part D coverage as a standalone prescription drug plan or as part of a Medicare Advantage plan. *See page 22.*

Point of Service plan (POS)

A type of Medicare Advantage HMO plan that helps pay for covered services received outside the provider network. You usually pay more for out-of-network care.

Pre-existing condition

A medical condition you have when you are applying for an insurance policy.

Preferred Provider Organization (PPO)

A type of Medicare Advantage plan that allows you to see doctors and hospitals either in the plan's network or outside of it. You will usually pay a larger share of the cost for care received outside the network.

Premium

A fixed amount you pay for Medicare coverage. You may pay the premium to Medicare, your Medicare plan or both, depending on your coverage. Most premiums are charged monthly. *See page 8.*

Prescription drug plan

A standalone Medicare Part D plan that helps pay for the cost of your prescription drugs. You may also get drug coverage with a Medicare Advantage plan. *See page 22.*

Preventive care

Medical care that is designed to keep you healthy or to find illnesses early, when treatment may be more effective. Examples of preventive care include diabetes screenings, flu shots and mammograms.

Private Fee-For-Service plan (PFFS)

A type of Medicare Advantage plan that allows you to use any doctor or hospital that accepts Medicare and agrees to the plan's terms and conditions of payment.

Provider

A person or organization that provides health care services, such as a doctor, hospital, pharmacy, laboratory or outpatient clinic.

Service area

The geographic area in which a Medicare Advantage plan operates. Plan members must live in the plan's service area. *See page 18.*

Skilled nursing care

Care provided by a licensed nurse.

Special Needs Plan (SNP)

A type of Medicare Advantage plan designed for people who have special health care needs. *See page 19.*

Step therapy

A type of prior authorization or pre-approval used in Part D where the plan requires you to try a less expensive drug to see if it works before a more expensive drug will be covered. *See page 23.*

Tiered formulary

A drug list organized into groups based on cost. For example, a generic drug may be on a lower tier and have a lower copay than a brand name version of the drug. *See page 23.*

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) offers free counseling and help with choosing Medicare coverage. There are SHIP offices in every state. Visit shiptacenter.org or call your state SHIP office.

Alabama
1-800-243-5463

Alaska
1-800-478-6065
In-state calls only
907-269-3680
1-800-770-8973 (TTY)

Arizona
1-800-432-4040

Arkansas
1-800-224-6330
501-371-2782

California
1-800-434-0222

Colorado
1-888-696-7213

Connecticut
1-800-994-9422
In-state calls only
860-424-5274

Delaware
1-800-336-9500

Florida
1-800-963-5337
1-800-955-8770 (TTY)

Georgia
1-866-552-4464

Guam
671-735-7415

Hawaii
1-888-875-9229
1-866-810-4379 (TTY)

Idaho
1-800-247-4422

Illinois
1-800-252-8966
1-888-206-1327 (TTY)

Indiana
1-800-452-4800
1-866-846-0139 (TTY)

Iowa
1-800-351-4664
1-800-735-2942 (TTY)

Kansas
1-800-860-5260

Kentucky
1-877-293-7447

Louisiana
1-800-259-5300

Maine
1-800-262-2232

Maryland
1-800-243-3425
In-state calls only
844-627-5465

Massachusetts
1-800-243-4636
1-877-610-0241 (TTY)

Michigan
1-800-803-7174

Minnesota
1-800-333-2433

Mississippi
1-844-437-6282

Missouri
1-800-390-3330
573-817-8320

Montana
1-800-551-3191

Nebraska
1-800-234-7119

Nevada
1-800-307-4444

New Hampshire
1-866-634-9412

New Jersey
1-800-792-8820
In-state calls only
1-877-222-3737

New Mexico
1-800-432-2080
505-476-4846

New York
1-800-701-0501

North Carolina
1-855-408-1212

North Dakota
1-888-575-6611
1-800-366-6888 (TTY)

Ohio
1-800-686-1578
1-614-644-3745 (TTY)

Oklahoma
1-800-763-2828
In-state calls only
405-521-6628

Oregon
1-800-722-4134

Pennsylvania
1-800-783-7067

Puerto Rico
1-877-725-4300
787-919-7291 (TTY)

Rhode Island
401-462-0510

South Carolina
1-800-868-9095

South Dakota
1-800-536-8197

Tennessee
1-877-801-0044
1-800-848-0299 (TTY)

Texas
1-800-252-9240

Utah
1-800-541-7735

Vermont
1-800-642-5119
In-state calls only
802-865-0360

Virgin Islands
1-340-772-7368 (STX)
1-340-714-4354 (STT/STJ)

Virginia
1-800-552-3402

Washington
1-800-562-6900
1-360-586-0241 (TTY)

Washington, D.C.
202-994-6272

West Virginia
1-877-987-4463

Wisconsin
1-800-242-1060
1-855-677-2783
1-888-758-6049 (TTY)

Wyoming
1-800-856-4398
307-856-6880

Contacts and websites

Medicare Helpline

Call for questions about Medicare and detailed information about plans and policies in your area.

1-800-MEDICARE
(1-800-633-4227)
TTY 1-877-486-2048

Medicare.gov

The Medicare website provides information and offers online tools to find and compare Part D plans, Medicare Advantage plans and Medicare supplement insurance plans.

Medicare & You

The official government Medicare handbook you may request when you call the Medicare Helpline, or you can download it at Medicare.gov.

Social Security Administration

Get answers to questions about Medicare eligibility and enrollment, Social Security retirement benefits or disability benefits. You can also ask about your eligibility for financial help.

1-800-772-1213
TTY 1-800-325-0778
SSA.gov/Medicare

Administration on Aging

Discover local, state and community-based organizations that serve older adults and their caregivers.

1-800-677-1116, TTY 711
Eldercare.gov

Your current health plan

Your health plan's customer service center should be able to answer questions you have about your current coverage. Find the number on the back of your member ID card.

AARP.org

AARP® provides information about Medicare, as well as other programs and services available to people as they age.

MedicareMadeClear.com

Watch videos, sign up for our newsletter, take quizzes, find helpful tools and get answers to your Medicare questions.

Medicaid.gov

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Learn more about eligibility, benefits and how to apply.

State Health Insurance Assistance Program (SHIP)

Your State Health Insurance Assistance Program offers free counseling and can help with questions about buying insurance, choosing a health plan and your rights and protection under Medicare. See pages 50–51 for the number in your state.

shiptacenter.org

National Hospice and Palliative Care Organization

Learn about hospice care and hospice programs where you live. Your doctor or other health care provider may also be able to help you find local services.

NHPCO.org

Medicare plan finder worksheet

Steps to finding a Medicare plan that's a good fit for you:



Learn about your choices.

Explore **MedicareMadeClear.com** for more information about Medicare, your choices and additional resources.



Understand your needs.

Think about how you use health care to help focus on the type of coverage that may work best for you.



Find plans in your area.

Go to Medicare.gov to get a list of plans available where you live and details about coverage and costs.



Compare your plan options.

Use the worksheet on the next page to compare plans based on your needs.



Select a plan.

Enroll online or call the plan directly.

Medicare plan finder worksheet

Compare costs

Fill out the chart with information from private insurance companies.

Tip

Some plans require a referral from your primary care provider to see a specialist. You may want to consider this as you compare your options.

| | Plan 1 | Plan 2 | Plan 3 |
|---|--------|--------|--------|
| Insurance company | | | |
| Name of plan | | | |
| Type of plan | | | |
| Original Medicare costs | | | |
| Monthly plan premium | | | |
| Emergency costs | | | |
| Estimated monthly copays/coinsurance | | | |
| Annual medical deductible | | | |
| Annual out-of-pocket maximum | | | |
| Annual prescription drug deductible | | | |
| Estimated monthly prescription drug costs | | | |

Compare coverage

If the plan covers the benefits or services, put a check mark in the box. For example, if a plan covers your current prescriptions, put a check mark in that box. If it does not, leave it blank.

| | Plan 1 | Plan 2 | Plan 3 |
|-----------------------|--------------------------|--------------------------|--------------------------|
| Current physician | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Current prescriptions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nurse phone line | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chiropractic care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acupuncture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Podiatry care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fitness benefit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Want to learn more?



Visit [MedicareMadeClear.com](https://www.MedicareMadeClear.com)

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