MEDICARE SURVIVAL GUIDE

Maximize Your Benefits | Minimize Your Expenses

- Joshua Mellberg -

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INTRODUCTION

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Understanding Medicare is a crucial step you must take to ensure that you or your family members are able to receive the best medical care possible for your unique situation. But it's not going to happen overnight.

Medicare is an enormous, powerful system meant to service citizens from all walks of life. Its various ins and outs may seem complex, but they are designed to give you the right tools to meet your own unique needs – all from one place.

It's also worth noting that Medicare initially looks much more complicated than it is. While it will take a little bit of time and reading to get a good handle on how Medicare works, once you've gotten the basics down, it will come quite easily and naturally to you.

To help get you more oriented, we've also included a handy glossary at the back, should you ever feel lost or needing more background.

At many places in this text, you may find us repeating key phrases, concepts, or dates. As unintuitive as it may seem, this is actually done to help make things as clear and easy as possible for you. What we've found is that when people (including us!) are trying to learn a new topic, it often takes a little bit of repetition to help jog our memories and get the concepts to stick.

We feel that this will pave the smoothest path into really, truly understanding Medicare that is possible.

The Time to Start is Now

It may be tempting to put this book aside and come back to it another day, but if you or a family member you're helping is approaching 65, you need to know now what you want to do.

This is true even if you plan to stay employed and continue to use your employer's insurance. Your still need to become familiar with how Medicare is going to impact you.

Why? A couple of reasons:

1. Under certain circumstances, you may be automatically enrolled in Medicare, even if you do nothing. This can pose a problem for people with HSA accounts.
2. There are a number of penalties applied to individuals who delay enrollment in Medicare. This is for people who aren't eligible for a Special Enrollment Period. These penalties could last for a few years or until the end of your life.

Needless to say, this is no small matter. And this is your life and your health we're talking about. We feel it's pretty important.

The purpose of this book is to bring you all the very best information you'll need to create a Medicare ensemble that fits your life. We have focused on bringing this information to you in clear, uncomplicated steps. Where things get hairy, we will go over it a couple of times from different angles.

You may find that one such approach makes things 'click' for you more than another, while your neighbor may find that a completely different approach clicks more for them.

At the end of the day, what matters is you. What matter is that you're not left out in the cold during the golden years of your life. You deserve to have your health taken care of in a way that won't leave you bankrupt.

That's what getting the most out of your Medicare plan is really all about.

History of Medicare

When Aime Forand was in the seventh grade, he dropped out of school. The reason? To care for his ailing elderly father. It seems only fitting that when Mr. Forand went on to become a successful United States Congressman, he would lobby to see that the elderly received the hospital care they often so desperately needed.

This wouldn't come until the end of a long and winding road spanning 30 years in the making to bring Medicare to America.

Franklin Roosevelt, as part of the New Deal legislation, worked to have a federal health insurance component in his Social Security Act of 1935, but he ended up not including it in order to ensure the bill would pass.

Fourteen years later, in 1949, President Harry Truman proposed a bill to the House of Representatives that would provide health insurance for those age 65 and older, but it was blocked by the Ways and Means Committee.

Forand, known as a 'New Deal' liberal, along with Congressman Cecil King, introduced legislation, a precursor to Medicare, to the House in 1957.

Then, in 1962, President John F. Kennedy sent the emerging bill to the Senate, where it narrowly missed passage by the Senate by just a few votes.

When President Lyndon B. Johnson took over President Kennedy's office after Kennedy was

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Photo credit: Franklin D. Roosevelt Presidential Library & Museum.
Photo credit: Vernon Galloway, Harry S. Truman Library & Museum.
Photo credit: Abbie Rowe, John F. Kennedy Presidential Library & Museum.

assassinated, he aimed to finish Kennedy's work – and it was in 1965, when President Lyndon Johnson believed "the times had caught up with the idea" and made Medicare a top priority in his administration. He said:

"Inadequate hospital care is an indecent penalty to place on old age."

Johnson viewed Truman as the one who "started it all" and signed Medicare into law on July 30th, 1965, at the Harry S. Truman Library and Museum in Independence, Missouri. Truman and Mrs. Truman witnessed it… and received the first two Medicare cards.

The Evolution of Medicare

When Medicare was first enacted in 1965, there were only Parts A and B – which is why these two parts are often called Original Medicare.

Today, Medicare consists of Parts A, B, C, and D, plus Medigap. In the next few sections, we'll take a look at how Medicare has been expanded to include these parts over the years.

Expansion to Cover the Disabled

In 1972, Congress passed a number of changes to Medicare expanding coverage to include those unable to obtain insurance for themselves due to disability. This change included individuals under the age of 65.

Photo credit: Harry S. Truman LIbrary & Museum.

Starting in 1972, Medicare also began covering necessary medical procedures for people with End Stage Renal Disease (ESRD). This included life-saving services such as dialysis and kidney transplants.

Expansion to Include Medicare Advantage Plans

The Balanced Budget Act of 1997 brought more major changes to how Medicare works.

This act introduced what are today called Medicare Advantage plans, though at the time they were called "Medicare + Choice."

This was the first time beneficiaries were able to choose a private insurance plan to receive their Medicare benefits through. These Medicare Advantage plans (or Medicare + Choice) gave retirees more flexibility as to how they received their benefits and what would be covered.

This same Balanced Budget Act of 1997 brought other changes, such as:

- An increase in premium payments from beneficiaries
- Heightened scrutiny of Medicare claims

Medicare's Role in Desegregation

Medicare works in some of the same ways as any other insurance provider – you go in, seek care, and then either you or the healthcare provider submits a claim for reimbursement to the healthcare provider – in this case, Medicare.

Here's the thing: in order for Medicare to pay providers, that provider must adhere to Medicare's rules. And Medicare's rules are very closely tied to the federal government's rules.

In 1966, some of the states and the federal government were in the midst of a momentous social, political, and legal dispute: segregation.

Many of the states wanted to keep their public spaces separated. The federal government, on the other hand, was working to eliminate this segregation.

When Medicare was enacted, patients who wanted their medical services covered by Medicare needed to seek care in a hospital approved by Medicare. If a hospital wasn't desegregated, however, Medicare wouldn't approve that hospital.

Translation: if hospitals wanted to attract patients and get paid, they had to be open to all races.

This was a ground-breaking change of the time in a lot of ways and helped to spur the desegregation movement along in America.

The Structure of Medicare

It may seem odd or complicated at first for people used to employer-sponsored insurance, but Medicare is broken down into 4 separate parts. These parts, combined, create a benefit that is more or less equal to what you may be used to from other insurance plans.

Each of these parts is funded in different ways (for instance, Part B is funded in part from premiums paid by beneficiaries while Part A doesn't receive premiums except in special cases). These parts all cover different types of services and have different rules applied to them.

These 4 parts are:

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Medicare Advantage
- Part D: Prescription Drug Coverage

Medigap plans are also an important part of Medicare but aren't considered one of the 4 "parts" of Medicare.

Some of these plans are mutually exclusive. In other words, you can't be enrolled in both at the same time.

Parts A and B are typically paired together (though they can also be used separately in special cases, for a limited time) and called Original Medicare.

Medicare Advantage plans replace Original Medicare. If you enroll in a Medicare Advantage plan, you can't also be enrolled in a Medigap plan (as well as not being enrolled in Original Medicare). Medicare Advantage plans can only be paired with Part D plans if the particular Medicare Advantage plan you've selected does not include drug coverage.

That may all sound confusing at first, so let's break it down into two ways that participants receive their healthcare coverage through Medicare:

Part A	Medicare Advantage
+ Part B	+ Part D (sometimes)
+ Part D	
+ Medigap	

While all of these parts are more or less optional, depending on your circumstance, if you choose to delay enrollment once you've become eligible, you could pay a higher premium on each when you do finally enroll. You will most often hear this extra amount referred to as a 'penalty.' In most cases, these penalties will apply to your Medicare premiums for the rest of your life.

Additionally, it's important to note that once you qualify for Medicare, you're not eligible to purchase non-Medicare healthcare insurance plans from the healthcare marketplace.

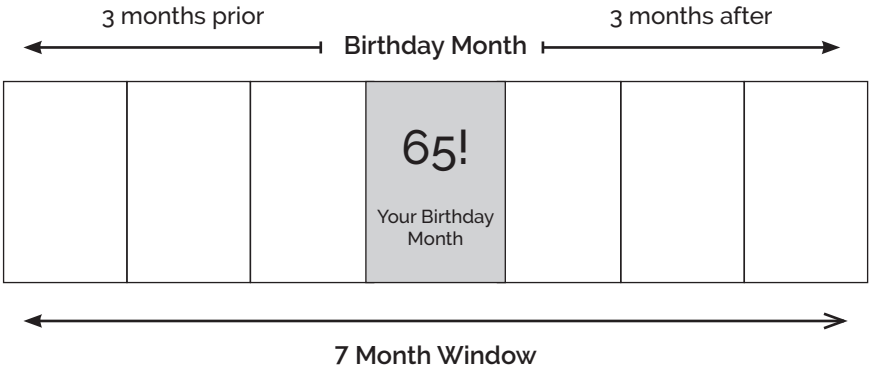
Getting Enrolled

If you're approaching age 65, you need to start thinking about what your Medicare plan is.

Many people find themselves in the unfortunate predicament of having assumed they could enroll in Medicare at their leisure only to find out they were slapped with penalties that last a lifetime. Don't fall victim to this situation! Make sure that you find out exactly what you need to do to enroll on time.

In general, you need to enroll in the 7 month window surrounding your 65th birthday.

This window opens 3 months before the month of your 65th birthday and closes 3 months after the month of your birthday. The entire month you turn 65 stands in the middle (unless your birthday falls on the 1st of the month, in which case Medicare considers your birthday to fall in the month prior. The same rules apply, but with the month prior in the center of your 7 month window).



This is called your Initial Enrollment Period.

If you're still employed, or on your spouse's insurance plan, you may not have to act on this Initial Enrollment Period. This is especially important to note if you're using an HSA (Health Savings Account) program through your employer's insurance.

In these cases, you may be eligible for a Special Enrollment Period.

In order to qualify, you must be insured through an employer with 20 or more employees. If your company has fewer than 20 employees, your employer-sponsored insurance will be considered secondary to Medicare. If this is the case, you need to enroll in Medicare within that 7 month Initial Enrollment Period to avoid the penalties associated with delayed enrollment.

We can't stress this enough. If you don't qualify for a Special Enrollment Period, it's really important that you get your Medicare set up during your Initial Enrollment Period.

This is NOT like Social Security where you not only have a choice of when to enroll, but are actually rewarded for delaying. When it comes to Medicare, you need to enroll on time.

It's also important to note that the age for receiving Medicare doesn't line up completely with Social Security's Full Retirement Age. While the Full Retirement Age for Social Security drifts, for people retiring / receiving Social Security today, the Full Retirement Age is 66. By contrast, the age for Medicare is 65.

Keep this in mind because getting the two ages mixed up could literally cost you!

MEDICARE PART A: **HOSPITAL INSURANCE**

PART A
HOSPITAL INSURANCE

In a nutshell, Part A of Medicare covers inpatient services. This applies chiefly to hospital stays, but also covers things such as inpatient skilled nursing facilities associated with hospital stays.

Skilled nursing care is covered by Medicare Part A, but it's important to note that this must be associated with medical care that must be administered by a nurse. This does not apply to Long-term care.

While many retirees may one day need long-term care in a nursing home, this must be arranged and paid for outside of Medicare.

Why is Original Medicare Split Into Two Parts?

In the mid-60s, before Medicare came around, a wide number of government surveys found that as many as 56% of seniors in America were without health insurance.[1]

While uninsured seniors at the time might spend around $1,289 a year in today's dollars on healthcare if there was no major hospitalization event, if those same retirees did have to go to the hospital, they often were paying around $7,000 in today's money for a single stay.[2] A report at the time noted, "Many aged persons never recover from the economic effects of a single hospital episode."[2]

And that was at a time when a hospitalization was considerably less expensive than it is today – even adjusted for inflation. As Henry Aaron puts it, "Health care was much less costly than it is today; and there was much less that doctors or hospitals could do for patients. It didn't cost much for a hospital to let a heart attack victim lie in a bed or for a physician to stop by and prescribe nitroglycerin for someone with angina. It is rather different when pain in the chest calls for angiography and possibly for angioplasty and costly maintenance drugs. It is the rare physician today who can afford to give a full work-up to a person who presents with persistent chest pains, which calls for thousands of dollars-worth of tests."

It became clear to policy makers that health insurance for the elderly was important and hospital insurance was of particular importance.

When Medicare was enacted, it came in two forms: one part that beneficiaries had to a pay a premium for, that was opted into manually, and another part that was free and automatic (so long as you had worked for at least 10 years).

The free and automatic one – the one that nearly every senior would have access to – was called Part A and covered the much-needed hospital insurance.

In this chapter, we'll discuss who qualifies for Medicare Part A, how much it costs, what it covers, and what you'll wind up paying for – even on covered services.

When Do I Qualify for Medicare Part A?

Unless you are receiving Social Security disability benefits or have End-Stage Renal Disease (ESRD), you won't qualify for Part A, or any other part of the Medicare program until you are at least 65 years old.

How Much Does Part A Cost?

For most seniors over 65, Medicare Part A is completely free. For anyone who has worked for at least 40 quarters (10 years) in qualified employment, there will be no premium for Part A.

For those who have worked less than 10 years, you can still opt into Part A for a premium of up to $411 per month, as of this printing (https://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-costs.html).

You can also get premium-free Medicare Part A if:

- You received Social Security or Railroad Retirement Board disability benefits for at least 24 months.
- You have End-Stage Renal Disease (ESRD). If you have ESRD, there may be additional requirements that need to be met before you're eligible for premium-free Part A Medicare.

Is There a Penalty for Delayed Enrollment in Part A Benefits?

Not unless you pay a premium for your Part A benefits. For those who receive it for free, there is no penalty for late enrollment, as there is with other parts of Medicare.

For those who will need to pay a premium for Part A, there are time-limited penalties for delaying your enrollment. For every year that you were eligible for Part A but didn't enroll, your premium will go up by 10% for twice the number of years you delayed enrollment.

That means that if you waited a year to enroll in Part A, then your premium will go up by 10% each month for two years.

Again, this is only for those who don't qualify for premium-free Part A benefits. For those who aren't required to pay a premium for their Part A benefits, there is no penalty (10% of 0 is still 0).

Under What Circumstances Might I Want to Delay Part A Benefits?

Because Part A is the free part of Medicare benefits (to those who have worked at least 40 quarters), there aren't many cases where you wouldn't want to take advantage of them.

One notable exception to this is if you are currently enrolled in an HSA program through your current insurance provider. Health Savings Accounts (HSA) are not permitted to those enrolled in Medicare. Enrollment in any Medicare program, including Part A could lead to a loss of your HSA account.

If you are currently insured through an employer with a group plan of 20 or more people, it is your choice whether or not to keep your current insurance plan or switch to Medicare. Any attempts made by your employer or insurance provider to get you to give up your current plan is illegal.

Hospital Coverage

In order for Part A to cover your hospital stay, you must first stay (and need to stay) at least 3 days in the hospital. This begins what's known as a "spell of illness." This is also sometimes called a "benefit period." Wherever you see either of thes terms – whether reviewing the Medicare website or reading other Medicare-related resources, these both mean the same thing.

What is a "Spell of Illness?"

A "spell of illness" begins on the first day that you're admitted to the hospital (and stay for at least 3 days), and ends after you have not been admitted to the hospital or related nursing care for at least 60 days.

For any one spell of illness, Medicare will pay various amounts depending on which day it is. For the first 60 days, you'll need to pay a one-time deductible of $1,216. The rest of those 60 days are more or less paid for by Medicare.

From day 61 to day 90, you'll be responsible for a co-pay of $315 per hospital day. Beyond 60 days, Medicare does not pay for the hospital stay.

Once one spell of illness, or benefit period, ends you are eligible for Medicare coverage on new hospitalizations.

What is a "Lifetime Reserve Day?"

Medicare has a provision of Lifetime Reserve Days. Medicare recipients have a total of 60 of these days available to be used in the recipients' lifetime. Should you find yourself in the hospital more than 90 days and you still have reserve days left, you have the option to use them.

Should you decide to use these reserve days, your co-pay will be $630 per day spent in the hospital. Medicare will cover the rest.

These rules apply to every benefit period. Please note that, unlike the way many insurance plans work, and indeed the way that other parts of Medicare work, a benefit period in this case does not refer to a calendar year.

Rather, it is related to your hospital stay. A benefit period, or a spell of illness starts after you have been hospitalized for at least 3 consecutive days (but is back-dated to the first day you were in the hospital once those 3 days have been met). The benefit period ends once you, the beneficiary, have gone 60 days without receiving hospital care or related inpatient nursing care pertaining to that same illness.

Once you have been out of the hospital and out of nursing care for at least 60 days, your spell of illness is considered over, as far as Medicare is concerned.

After that, if you're re-hospitalized, the process starts over again.

What if My Hospital Stay is Less Than 3 Days?

If you are admitted into the hospital, but stay less than three days, Medicare will not cover your expenses. You must stay at least three days to activate Medicare coverage.

Hospice Care under Part A

Hospice care is provided to those individuals who are terminally ill with a life expectancy of less than 6 months. Some patients may live beyond this 6 months, in which case they would need a renewed assessment by a certified physician stating that the patient is terminally ill and not expected to live more than 6 months.

In these situations, treatments for the illness are no longer being made and care shifts to a concern for the patient's comfort, dignity, and psychological wellness in their final days.

Hospice care is almost entirely covered under Medicare Part A. Unlike hospital care under Part A, there are very few – if any – copayments to be made by the beneficiary or the beneficiary's family for hospice care. The hospice care, itself, is not billed to the beneficiary. Certain aspects of hospice care might not be included, depending on the circumstances, but the actual care you receive from hospice is completely covered by Medicare.

Some things that may not be covered are:

- Room and board if hospice care is provided in your own home, or in a nursing facility where you live.
- Some prescription drugs may not be provided under the Part A section of hospice care, but might be covered under Part D: Prescription Drug coverage.
- You may need to pay a small co-payment for short-term respite care.

It should be noted that hospice care is only provided for terminal cases where no more work is being made towards a treatment for the illness. Any medications prescribed for treatment of the illness will not be covered.

Services, prescriptions, and equipment covered in hospice care by Medicare are intended for the management of symptoms and pain relief.

Should you and/or your physician, for any reason, wish to resume your treatment, you have the right to do so. At this point, hospice care and coverage will cease and treatment will be covered under their relevant parts of Medicare.

Long-Term Care

It often comes as a surprise to seniors and retirees that Medicare does not cover Long-term care or Activities of Daily Living.

Medicare is a program designed to meet the peoples' medical needs. If you are in a care facility related to an illness or injury and need Skilled Nursing care, Medicare may pay for that as outlined by the benefit period rules associated with Hospital Care. See our chapter on Part A coverage for more information on how nursing care is covered.

It's important to note that in any section discussing Medicare where inpatient care from a Skilled Nursing Facility is covered, this only pertains to care administrated in relation to hospitalization. It must be a medical need.

Care from a Skilled Nursing Facility should not be confused with care received in a "nursing home." Nursing home costs will not be covered by Medicare.

Many elderly beneficiaries may one day need long-term care, but those costs will need to be paid by some means other than Medicare.

Is There Anything I Can do to Mitigate the Costs Medicare Does Not Cover?

Yes. There are supplemental (Medigap) and Medicare Advantage (Part C) plans that may cover other needs you may have. For more on the coverage these plans offer, turn to chapters 3 and 6. In addition, Long-term care can be covered through the purchase of Long-term care insurance, if you so choose.

MEDICARE PART B:
MEDICAL CARE

PART B
MEDICAL CARE

Part B is a massive, robust part of Medicare. It covers a great deal of the needs of beneficiaries. Part B includes everything from preventive services to diagnostics, to medical treatments, to ambulance transportation (and more). Part B even covers such needs as outpatient surgeries.

When Medicare was first created, it consisted of Parts A and B. Today, these two parts are called "Original Medicare." Of Original Medicare, everything that isn't covered in Part A – hospital insurance – is covered under Part B, including:

- Doctor's visits
- Preventive services
- Durable medical equipment
- Clinical research
- Ambulance services
- Inpatient, outpatient, and partial hospitalization for mental health issues
- Limited outpatient prescription drugs

How Much Does Medicare Part B Cost?

Every year, there is a set premium for Medicare Part B. Some years (such as in 2016), this price stays the same as it was in the previous year. Most years, the price goes up. In 2015 (and 2016), the premium was $121.80.

If the Medicare coverage you had was Original Medicare, and you qualified for premium-free Part A (as most Americans do), your premium for all of Original Medicare would be $121.80.

People in higher tax brackets may have to pay more in Part B premiums. This only applies to people who file individually and make more than $85,000 per year, or couples who make over $170,000 per year. These amounts are referred to as Modified Adjusted Gross Income (or MAGI).

The following table outlines how much more those in these higher tax brackets will be paying as of this printing. Keep in mind that these amounts are above and beyond the standard $121.80 Part B premium.

If your yearly income in 2014 was:

File individual tax return	File joint tax return	File married & separate tax return	You pay (in 2016)
$85,000 or less	$170,000 or less	$85,000 or less	$121.80
above $85,000 up to $107,000	above $170,000 up to $214,000	Not applicable	$170.50
above $107,000 up to $160,000	above $214,000 up to $320,000	Not applicable	$243.60
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 and up to $129,000	$316.70
above $214,00	above $428,000	above $129,000	$389.80

Is There a Penalty for Delaying Enrollment in Part B?

Yes.

While there's no penalty for not having Medicare Part B, it's safe to say that you will need it eventually. It's when you finally do enroll in Medicare that the delayed enrollment penalties begin to apply.

If you delay enrollment in Medicare Part B, your monthly premium could go up by 10% for each full 12-month period that you were eligible for Part B, didn't have other creditable coverage and didn't enroll.

This penalty is permanent. It's also important to note that the penalty is calculated based on a percentage of your Medicare premiums for that year. If the premiums go up in subsequent years (as they usually do), so will the penalty amount.

Important Note for Those Who Choose Medicare Advantage Plans

While Medicare Advantage plans are more or less separate from Original Medicare and purchased through private insurance companies, the premiums due to Medicare as well as the Modified Adjusted Gross Income (MAGI) will still need to be paid, even if the premium quoted to you by your private insurer is different.

Assignment

One of the most important parts of having your medical care covered by Medicare is seeing doctors who accept assignment.

There are three kinds of doctors whom you may find yourself wanting to receive care from:

- Doctors accepting assignment
- Doctors not accepting assignment
- Doctors not participating in Medicare

If a doctor accepts assignment for the service(s) they provide to you, they agree to 3 things:

1. That they'll be paid directly by Medicare
2. That they'll only charge the amount Medicare approves for the service
3. That they won't bill you for more than the Medicare deductible and coinsurance

These same rules of assignment not only apply to physicians, but also to providers of medical equipment and prescriptions.

Durable Medical Equipment

Medicare Part B also covers what's referred to as "durable medical equipment."

This is equipment prescribed by a physician for in-home medical use. It's important to note the Medicare will only cover this kind of medical equipment if both the physician and supplier are enrolled in Medicare. This is even if the equipment is medically necessary.

- Air-fluidized beds and other support surfaces (these supplies are only rented)
- Blood sugar monitors
- Blood sugar (glucose) test strips
- Canes (however, white canes for the blind aren't covered)
- Commode chairs
- Continuous passive motion (CPM) machine
- Crutches
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

Preventive Care

One of the most important parts of your Medicare coverage is your preventive care. This helps everybody involved, including Medicare, and as such, they give you a lot of options here.

The best part about these preventive services is that they are often free for the first 12 months of enrollment and then again during your annual wellness check-ups each year after that.

Preventive services include:

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings & counseling
- Bone mass measurements (bone density)
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy)
- Cervical & vaginal cancer screening
- Colorectal cancer screenings
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Nutrition therapy services

- Obesity screenings & counseling
- One-time "Welcome to Medicare" preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Shots:
    - Flu shots
    - Hepatitis B shots
    - Pneumococcal shots
- Tobacco use cessation counseling
- Yearly "Wellness" visit

As with the durable medical equipment stipulation, providers of preventive services must accept assignment. For more information on assignment, please refer back to page 37.

How to Find Out if Your Item or Service is Covered

Because Medicare Part B covers such an enormous scope of medical needs, it would be impossible to list them all here. But, Medicare has provided an easy-to-use resource to help you with this.

You can visit: https://www.medicare.gov/coverage/your-medicare-coverage.html and type any test, item, or service you're looking for. Medicare's website will return results informing you of the coverage status of your query.

Mental Health

Your mental health matters. We all know it's important to take care of our physical health, but all too often we neglect our mental health.

The truth of the matter is this: your mental health has a huge impact on your quality of life. We can also get ourselves into a trap where we expect that we should be able to fix ourselves all on our own and that if we don't, it's our fault. This isn't the reality of how your brain works.

Your mental health is part of an organic system just like the rest of your body and sometimes you need the assistance of someone who understands how that organic system works. There's nothing wrong with that. In fact, in many cases, getting this assistance can have a rippling affect throughout the rest of your life, including how happy and successful your retirement is.

Medicare recognizes this and covers mental health services from a variety of sources, including:

- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant

As with all other medical services covered by Medicare, it's important to note that these visits are only covered by Medicare when they're provided by a health care practitioner who accepts assignment (for more on assignment, flip back to page 37.

Need help overcoming a drug addiction or alcohol abuse? Medicare often covers this treatment, as well.

As far as outpatient services go, Medicare covers the following:

- Depression screenings (once per year). These screenings don't necessarily need to be performed by a psychiatrist. For these particular screenings, Medicare will only cover it if they are administered by your primary care provider. From there, they can provide follow-up treatment and/or referrals, as needed.

- Individual and group psychotherapy sessions – not to be confused with support groups. The difference between group therapy (covered) and support groups (not covered) is often that the former is overseen by a certified psychotherapy doctor or other approved licensed professionals. The latter can be any group of people who get together to provide one another with emotional and social support.

  Often individual and group psychotherapy sessions will need to be approved by Medicare, a local representative, or a healthcare or mental care provider. Always double check to be sure these services will be covered.

  Family counseling. Keep in mind that general family counseling is often not covered by Medicare. Cases where it would be covered are generally related to the family counseling being necessary to complement your treatment for other mental health needs.

- Psychiatric evaluation.

- Medication management. Keep in mind that most prescription drugs will be covered under Medicare Part D plans, which you must buy separately.

- Some prescription drugs. This is a very select group of prescription drugs covered – namely those that typically are not self-administered. Often these are drugs that must be injected, rather than taken orally, but could apply to other situations, as well. Check with your provider to see if your medications will be covered under Part B or Part D.

- Diagnostic tests.

Outpatient Mental Healthcare Costs Under Original Medicare

Your yearly depression screenings will be covered in their entirety if you see a doctor who accepts assignment.

For diagnostics, you pay 20% of the Medicare-approved amount. You'll need to meet your Part B deductible first.

Additional copayments or coinsurance may be due for services received in a hospital outpatient clinic or hospital outpatient department.

An Important Note about Recommended Services vs. What's Covered

It's important to understand that some services may not be covered, even if your healthcare provider recommends them. This may apply to specific services or to the frequency your provider recommends receiving those services.

It's always a good idea to keep an open dialogue with your healthcare provider to find out if certain services will be covered.

Costs may also differ across different services or depending on how often you receive those services – even if they are covered. These costs can vary for a number of reasons, including based on whether or not your chosen provider accepts assignment.

Outpatient Drugs Covered by Medicare Part B

As we mentioned earlier, prescriptions are generally covered under Medicare Part D. That said, there are a number of prescriptions that will be covered by Part B, under certain circumstances.

For the most part, the only prescriptions that will be covered under Part B are those that you wouldn't administer to yourself. That could mean drugs that are administered in a doctor's office or clinic, or hospital outpatient setting.

As a general rule of thumb, if you can take the drug yourself at home, it won't be covered under Medicare Part B.

Some exceptions to this are:

- Prescriptions used with durable medical equipment. If your prescription requires a nebulizer, infusion pump, or other types of medical equipment, it may be covered under Part B.

- Injectable or infused drugs. Drugs that must be administered by a licensed medical practitioner are generally also covered under Part B.

- Antigens. This does not apply to all antigens, but only those that are prepared by a doctor and administered by a trained individual (which could include the patient, under certain circumstances). Antigens covered under Medicare Part B generally need to be given to the patient under appropriate supervision.

- Injectable osteoporosis drugs. If you are a woman with osteoporosis meeting the criteria for Medicare home health benefits and have a bone fracture that a physician certifies is related to post-menopausal osteoporosis, Original Medicare may help pay for your injectable osteoporosis medication. Again, this doesn't apply to all such situations. A doctor must certify that you are not able to administer the injection yourself, and will not become able.

  In most cases, only the medication will be covered. Coverage for a home health nurse or aide who administers the drug will only be provided if there are no family and/or caregivers able to give you the injection.

- Erythropoisis-stimulating agents. If you have End-Stage Renal Disease (ESRD) or need erythropoietin to treat anemia, Medicare may help cover this drug.

- Oral End-Stage Renal Disease (ESRD) drugs. In some cases, injectable ESRD drugs may also be available in oral form. If the injectable form is covered by Medicare Part B, the oral form usually is, as well.

  Blood clotting factors. Medicare helps pay for injectable clotting factors needed by hemophilia patients.

- Parenteral and enteral nutrition (intravenous and tube feeding). For patients unable to absorb nutrients through their intestinal tract or unable to take food by mouth, Original Medicare will cover the costs of medical equipment necessary to keeping the patient nourished.

- Intravenous Immune Globulin (IVIG) provided in the home. If you have primary immune deficiency disease and a doctor certifies that it is medically necessary or appropriate for you to receive IVIG in your home, Part B may cover the IVIG. It's important to note that while Part B will cover the IVIG, itself, it doesn't pay for other items and services relating to its administration in the home.

- Transplant drugs. Sometimes referred to as immunosuppressive drugs, this medication may be covered by Medicare if Medicare helped pay for the organ transplant, itself. If the transplant wasn't covered by Medicare, these immunosuppressive drugs are often covered under Medicare Part D plans (rather than Part B).

- Injectable cancer drugs and oral equivalents. In general, injectable cancer drugs will be covered under Medicare Part B. If there is an oral version of this same drug, it will also likely be covered under Part B.

- Chemotherapy-related anti-nausea drugs. As many of the anti-nausea drugs administered along with anti-cancer chemotherapy treatment are injectable, they are typically covered under Medicare Part B. As with many of our previous examples, if there is an oral version of this same medication, it may also be covered.

  For this coverage to apply, the anti-nausea medication must be given either immediately before or within 48 hours of the chemotherapy medication.

- Typically, any injectable or intravenous medications will be covered under Medicare Part B.

Outpatient Drug Costs Under Part B

As with other costs for services and items covered under Part B, you must meet your Part B deductible before Medicare pays anything for your Part B-covered drugs (if you'd rather not be subject to this deductible, there are Medigap plans that can cover this for you. For more on Medigap, turn to page 73.

For drugs you receive through a doctor's office or pharmacy, once the deductible is met, you pay 20% of the Medicare-approved amount for doctors and other providers who accept assignment.

If you're receiving these drugs through a hospital outpatient setting, a copayment applies. Talk to your provider to find out what this copayment is for specific drugs.

If there is a drug you need that is not covered under Medicare Part B, it may be covered under Medicare Part D. Check with your Part D provider to see if it's covered. If you don't have Part D or if it's not covered, you could be paying 100% of the costs, so it's always a good idea to double check everything you're getting with your healthcare provider.

MEDICARE PART C:
MEDICARE ADVANTAGE

PART C
MEDICARE ADVANTAGE

What you get from Original Medicare (that is – Parts A & B), is standardized across the board.

Everybody with Original Medicare gets the same benefits, has the same items covered, pays the same base premium, has the same deductibles, has the same co-pays, etc. If you have different medical needs, or would like to have smaller co-pays, a cap on out-of-pocket costs, or extra services such as hearing, vision and dental care, you may want a Medicare Advantage plan.

Here's how it works. You still have to pay the base premium you otherwise would for Medicare Part B plus any extra amount required by your income level. If you're not eligible for premium-free Medicare Part A, you need to pay that premium, as well.

In turn, each month, Medicare pays a fixed amount to your Medicare Advantage provider. In order to qualify for this arrangement, that provider must follow Medicare's rules.

How much you wind up paying out-of-pocket while using these plans will depend on a number of things, including:

- Whether the plan charges an additional monthly premium on top of the premiums owed to Medicare

- Whether or not your chosen plan pays for any of your Medicare Part B premiums

- What your deductible is, if you have a deductible

- What your plans copayments and deductibles are for various services, items, or prescriptions. These amounts may be different than those offered under Original Medicare

- How often you go to the doctor and what types of services you need or use

- Whether or not your doctor or medical equipment provider accepts assignment (for times when you go out-of-network while on PPO, PFFS, or MSA plans)

- Whether or not you need extra benefits

- Your individual plan's out-of-pocket limit

- Whether or not you qualify for Medicaid in your state (and enroll to receive assistance from them)

Medicare Advantage plans are offered through private insurance companies. If this style appeals to you, shop around and find the Medicare Advantage plan you want. The plan must be offered in your area.

Each plan will have its own benefits and its own premium (on top of the premiums required by Original Medicare). Premiums for Medicare Advantage plans are often higher than those for Original Medicare because they offer more.

Once you're enrolled in a Medicare Advantage plan, the private insurance company you're enrolled with will receive a set amount from Medicare to supplement the benefits they'll provide for you.

Medicare Advantage plans are required to give you at least everything you would receive from Original Medicare.

How Can I Make A Plan Change?

To switch to a new Medicare Advantage Plan – join the new one during one of the enrollment periods and you will no longer be enrolled in the old plan when coverage from the new one begins. (October 15 - December 7)

To switch to Original Medicare – you can contact your current plan or call **1-800-MEDICARE (1-800-633-4227)**.
Enrollment period for this is October 15 - December 7.

Your Choice of Provider/Doctor

When you have Original Medicare, you're able to receive your medical care from any Medicare-approved physician or care facility in the country. When you go with a Medicare Advantage plan, the private insurance company you received the plan through will usually (almost always) have stipulations as to who you can see.

For the most part, on a Medicare Advantage plan, you'll be limited to seeking care with providers only within that insurance company's provider network. How much you'll have to pay for out-of-network providers will depend on whether you've gone with an HMO or PPO.

Another consideration is whether or not you'll want to see a specialist. If you have Original Medicare, you do not need permission or a referral from your Primary Healthcare Provider [or does PHP stand for physician?] to see a specialist doctor. If you are going with a private insurance company, on the other hand, this may not be the case. As with many other particulars of Medicare Advantage care, it will all come down to the rules your insurance company has set down.

In many cases, they will require getting a referral from your primary doctor before you're able to see a specialist.

Important Note About Prescription Drug Coverage

When Medicare Advantage was originally formulated, there was no Medicare Part D. At the time, Medicare Advantage was called Medicare + Choice.

These plans often did not offer prescription drug coverage. Some of them may still not offer this coverage. In other cases, you may find that if you have had your Medicare Advantage or Medicare + Choice plan for a long time – since before the introduction of Part D in 2003.

If this is the case, you may still be eligible to sign up for Medicare Part D: Prescription Drug Coverage.

If your Medicare Advantage plan does cover prescription drugs, however, then you can't sign up for Medicare Part D.

MEDICARE PART D: **PRESCRIPTION DRUG COVERAGE**

PART D
PRESCRIPTION DRUG COVERAGE

Through your employer-sponsored health insurance, which you may have been used to your whole life, prescription drug coverage is usually included with everything else. In Medicare, it's separated out into a separate part.

For the most part, you'll only use Part D with Original Medicare. If you've chosen to go the Medicare Advantage route and that Advantage plan has prescription drug coverage, it's not legal to add a Part D plan on top of that.

If your Medicare Advantage plan does not include prescription drug coverage, on the other hand, you may be able to add Part D.

Much like Medicare Advantage (Part C) or Medigap plans, Medicare Part D plans are provided to you through private insurance companies.

What you get out of these plans, as well as your premium amounts, can often vary from provider to provider. Shopping around for the right plan to fit your needs is a great way to keep your costs down while still getting the prescriptions that you need.

What Does Medicare Part D Cover?

Part D specifically covers prescriptions drugs. It does not cover any medical services, hospitalizations, or any other medical costs.

How Much Does Medicare Part D Cost?

The costs associated with Medicare Part D come in the following forms:

1. Plan (Premium $15-$115, Deductible $0-$360)
2. Drug Costs
3. Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
4. Late Enrollment Penalties

Those receiving payment assistance aside, all those who get a Part D plan will have to pay the premium. If you end up needing prescription drugs throughout the year, you'll also be paying various copayment or coinsurance amounts.

Only those who make substantially high income will have to pay the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA).

Late enrollment penalties only apply to those who not only delayed enrollment in Medicare Part D, but also had no creditable coverage in the interim.

We'll go over each of these costs in the following sections.

Is There a Deductible for Medicare Part D Plans?

Because Part D is offered through private insurance companies, how much your deductible is depends on the plan you went with.

The deductible on any insurance plan is the amount you have to pay before your plan starts paying its share of expenses.

Some plans may have no deductible at all, while others could be as high as $360.

It should be noted that while each plan decides its own deductible amount, Medicare sets a cap each year on how high this deductible can be. In 2015, the deductible could be no higher than $320. In 2016, the deductible for a Part D prescription drug plan can be no more than $360.

How Much Do You Pay for Prescription Drugs on Part D?

Because your Part D coverage is provided by private insurance companies each offering their own mix of benefits and restrictions, how much you wind up paying for your prescriptions can vary. Some other factors that will alter how much you pay are:

- What drugs you're prescribed
- Whether your pharmacy is in-network or out-of-network
- What drugs your plan covers
- The coverage your unique plan offers

There are four basic phases of drug coverage when you're on almost any Medicare or Medicare Advantage plan:

1. The deductible phase. While some Part D plans won't have any deductible, most do. Medicare puts a cap every year on how high that deductible can go. In 2016, that cap was set at $360. The deductible on your plan may be as high as that, or it may be lower.

   Whatever your deductible is, you pay 100% of your prescription drug costs until you reach that deductible.

   Once that deductible is met, you move into the next phase.

2. Initial coverage limit phase. During the initial coverage limit phase, you will likely have a coinsurance or copayment due on each prescription of various amounts. After you pay your portion of the drug costs, your Part D plan provider and Medicare will pick up the rest.

   For example, if your plan includes a 25% coinsurance and your medication costs $100 retail, you'll pay $25 coinsurance.

   Many providers have different coinsurance and copayment amounts for generic brands versus prescription brands.

   This initial coverage phase has a limit. For example, that limit may be $3,310 (this limit can vary from year to year and even plan to plan). Once the total costs for your prescription drugs that year reach this amount, you enter the next phase. Please keep in mind that everything paid by both you and the plan provider counts towards this limit.

3. Coverage gap – or "donut hole." Once you and your insurance provider have hit your initial coverage limit, there is very little coverage from your provider for prescription drugs.

   Initially, nothing was covered by your Part D plan when you were in the coverage gap. Then, in 2010, came the Patient Protection and Affordable Care Act (PPACA)..

   As part of the changes mandated by PPACA, this coverage gap will lower in incremental amounts until 2020, when there will be no more gap. After 2020, coinsurance amounts will go down to 25% just as they are in the previous phase. Keep in mind that your coinsurance amount during this gap was 100% (meaning you paid the full amount) in 2009, before PPACA.

   As of 2016, the coinsurance amount most enrollees pay while in the coverage gap is 45% on brand-name drugs and 58% on generic drugs.

   This gap will continue to close over the next several years in the following increments:

	You'll pay this percentage for brand-name drugs in the coverage gap	You'll pay this percentage for generic drugs in the coverage gap
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

A note about percentages: The percentage coinsurance you're responsible for on generic and brand name prescription drugs can often confuse people. Depending on your plan, you may find that you pay a higher coinsurance percent on generic drugs versus brand name drugs.

For example, the standard coinsurance for enrollees during the coverage gap is:

45% for brand name drugs
58% for generic drugs

Many people look at this and wonder why they have to "pay more" on generic drugs than they do for brand name drugs. The thing you have to remember here is that we're talking about percentages, not final cost – and brand name drugs cost a lot more.

For example, according to Select Health's website (http://selecthealth.org/blog/2014/02/generic-drugs/), the price for the brand name Abilify is $688, while the generic alternative is $18.

When you pay your 45% brand-name coinsurance on Abilify, your total comes out to $309.60. When you pay your 58% generic coinsurance, your total comes out to only $10.44.

Even though your coinsurance is higher for generic drugs, you still end up paying a lot less most of the time.

4. Catastrophic coverage phase. Just as all the previous phases had limits, so does the coverage gap. Once you and your Part D provider have spent a total of $4,850 for your prescription drugs in a year, you leave the coverage gap and enter the catastrophic coverage phase.

As with all other dollar amounts, this changes from year to year. The $4,850 limit is for 2016.

Once you reach this phase, you pay significantly less on all your prescriptions for the rest of the year – usually around 5% of the retail price. The rest is covered by a combination of Medicare and your Part D plan provider.

Part D Late Penalties

As with other parts of Medicare, if you don't enroll when you first become eligible, there may be a late penalty applied to your payments when you do enroll.

While you don't have to pay the penalty during the months or years you're not enrolled, once you have enrolled and the penalty is applied, it often remains until you're no longer enrolled in Medicare. In other words, it will likely last the rest of your life.

For Part D, the penalty added to your monthly payment due is 1% of the "national base beneficiary premium" per full month you went without creditable coverage. For reference, the "national base beneficiary premium" in 2016 was $34.10.

So, for example, if you delayed enrollment in Part D for a full 11 months after you were eligible without other creditable coverage, your Part D penalty in 2016 would be 11% of $34.10, or $3.80. The penalty calculated is rounded up to the nearest 10 cents ($0.10).

Compare this to the Part B penalty which is 10% for each full 12-month period you could have enrolled but did not, and didn't have any other creditable coverage. With our example above, if you delayed signing up for both Parts B and D for 11 months, your Part D penalty would be 11% of the

national base beneficiary premium, while your Part B penalty would be… nothing.

Each penalty period has to last for the full period, or it won't be counted.

Can You Get Your Part D Premium Automatically Deducted?

For many people, it may be easier to have their Part D payments automatically deducted along with their other Medicare payments deducted from their Social Security checks. You may find that for your situation this eliminates a lot of the hassle you might otherwise have to go through.

If you feel this is the case, let your Part D insurance provider know. Many people call the Social Security Administration trying to get their Part D payments taken out automatically, but Social Security isn't able to do anything about this.

When you opt to have your Part D payments taken out of your Social Security checks, there are somethings you may want to know:

1. It can take about 3 months for the first deduction to be taken out of your Social Security check.
2. When Part D deductions do start, the first 3 months of Part D premiums will likely be deducted at once.
3. There may also be deduction delays if you switch plans.

As always, if you want to make any changes to this set-up, let your drug plan provider know. This applies to whether or not you want to stop deductions, as well as letting new providers know what you want to do as far as deductions go.

Important Information: If You are a High-Income Earner

If you are a high income earner, you may have to pay an additional amount on top of your regular Part D payments.

This amount is called Part D-IRMAA, or Part D income-related monthly adjustment amount.

While your Part D premium is paid to your plan provider, the Part D-IRMAA is paid either to Medicare or the Railroad Retirement Board – whichever is applicable to the benefits you receive. This is true regardless of whomever you might be receiving your Part D coverage from.

If you're receiving Social Security or Railroad Retirement Board Benefits, the Part D-IRMAA will often be taken straight out of those benefit checks. If not, then you receive a notice in the mail with details regarding how to make these adjusted payments.

Curious how much extra you might be paying? The chart below outlines the basic thresholds Medicare uses plus the extra amount to be paid for each threshold.

If your filing status and yearly income in 2014 was:

File individual tax return	File joint tax return	File married & separate tax return	You pay (in 2016)
$85,000 or less	$170,000 or less	$85,000 or less	your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$12.70 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	above not applicable	$32.80 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$52.80 + your plan premium
above $214,000	above $428,000	above $129,000	$72.90 + your plan premium

Your income threshold is based on your filing status two years prior.

As with premium amounts, these numbers can change from year to year. If you would like to contest having to pay this amount, you can visit https://www.ssa.gov/forms/ssa-44.pdf to find the form you'll need to fill out and send to the Social Security Administration.

What if I Don't Pay the Part D-IRMAA?

For those who qualify to pay a Part D-Income Related Monthly Adjustment Amount, you're required by law to make these payments. If you decide you don't want to pay it and stop, you'll lose your prescription drug coverage.

Keep in mind that if you simply don't enroll in Medicare Part D in order to avoid these payments, but you later need prescription drug coverage, when you do enroll in Part D, there will be a late enrollment penalty directly corresponding to how long you waited to enroll.

Tips for Keeping Your Prescription Drug Payments Low

If you're starting a new drug, you may want to talk with your doctor or prescriber about getting a smaller quantity to start out with in case you wind up needing to switch prescriptions later.

While most prescriptions come in 1 month supplies, getting a smaller batch can save you money if the medication doesn't work out well for you.

Always be sure to work this sort of situation out with your healthcare provider first!

MEDIGAP

MEDIGAP

It's easy to get Medicare Advantage plans and Medigap confused, but the truth is that these are each very different coverage options.

Medicare Advantage plans are usually comprehensive health insurance plans that cover most of your healthcare needs. These Medicare Advantage plans are provided by private insurance companies and can feature a mix of different benefits and costs. While Medicare does place several regulations applied to them, they can vary a great deal from one to the next.

The way Medicare Advantage plans work is that an insurance company will decide what they want to offer in their Advantage plan and sell it. If you buy it during any of the enrollment periods available to you, Medicare will then pay a set amount to the plan provider to cover some of your costs.

These Medicare Advantage plans replace Original Medicare (Parts A and B) and often replace Part D, as well.

Medigap plans, by contrast, offer a very limited range of benefits that are predetermined by Medicare. There are currently ten Medigap plans that insurance companies can offer. There are also some Medigap plans that are being phased out, but we'll get to all of that in a minute.

Here's a chart that summarizes the two choices.

	Medigap	Medicare Advantage
How it relates to Original Medicare Parts A & B	Private supplemental coverage that pays all or most Part A & B out-of-pocket costs.	Private health plan that provides Part A & B benefits directly in place of Original Medicare.
Premium	Average of about $150 to $200 a month. Can vary by age, health history, or both.	$0 to more than $100 a month depending on the plan. All plan enrollees pay the same regardless of age or health history.
Out-of-pocket costs	Low to none (not counting premium).	In-network medical deductibles and co-pays of up to $3,400 to $6,700 a year, depending on the plan.
Choice of doctors and hospitals	Any that participate in Medicare.	HMOs: Plan providers only. PPOs: Any provider, but out-of-network providers cost more.

	Medigap	Medicare Advantage
When you can buy	First six months after you sign up for Part B and are at least 65 years old. After that, in most states you can be turned down or charged extra for pre-existing conditions.	When you first enroll in both Medicare A and B and annually thereafter during Open Enrollment (Oct. 15-Dec. 7).
Part D (drug) coverage	Not included. You must buy a separate Part D plan for this.	Most plans include Part D coverage.
Quality information available	No. There are no standardized ratings for Medigap plans.	Yes. Medicare.gov has star ratings (5 stars are the best).
Cards in your purse or wallet	Three. 1. Red, white, and blue Medicare card. 2. Medigap card. 3. Part D card.	Usually just one Medicare Advantage card. The red, white, and blue Medicare card can stay in your desk drawer.
Paperwork	Little to none. Medigap almost always automatically cuts a check to providers after Medicare pays its share.	Some, because you pay deductibles and copays directly to providers.

The benefits that you can get from a Medigap plan are as follows:

- Medicare Part B preventive care coinsurance
  Medigap plans offering this benefit: ALL

- Medicare Part B copayment or coinsurance coverage
  Medigap plans offering this benefit in full: A, B, D, F, G, M, N
  Medigap plans offering this benefit, partially: K (50%), L (75%)

- First 3 pints of blood
  Medigap plans offering this benefit in full: A, B, C, D, F, G, M, N
  Medigap plans offering this benefit, partially: K (50%), L (75%)

- Skilled Nursing Facility (SNF) care coinsurance
  Medigap plans offering this benefit in full: C, D, F, G, M, N
  Medigap plans offering this benefit, partially: K (50%), L (75%)

- Medicare Part coinsurance hospital costs up to an additional 365 days after Medicare benefits are exhausted.
  Medigap plans offering this benefit: ALL

- Part A hospice care coinsurance or copayment.
  Medigap plans offering this benefit in full: A, B, C, D, F, G, M, N
  Medigap plans offering this benefit, partially: K (50%), L (75%)

- Medicare Part A deductible.
  Medigap plans offering this benefit in full: B, D, F, G, N
  Medigap plans offering this benefit, partially: K (50%), L (75%), M (50%)

- Foreign travel emergency coverage (up to plan limits). Medigap plans offering 80% coverage for this benefit: C, D, F, G, M, N

- Medicare Part B deductible.
  Medigap plans offering this benefit: C, F

- Medicare Part B "excess charges."
  Medigap plans offering this benefit: F, G

While you'll usually see a chart more like the one below when referencing Medigap, we find that laying it out the way you see above this paragraph gives retirees a better idea of what the value of a Medigap plan really is.

It's the part of Original Medicare that gives you more control over how your healthcare coverage will go to work for you.

The following table illustrates what each plan offers:

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	No
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	75%	50%	75%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$4,960	$2,480	N/A	N/A

*Please see the next page for * information.*

**Plan F also offers a high deductible plan. If an individual chooses this option, this means that Medicare-covered costs up to the deductible amount must be paid for by the policy holder before the Medigap plan pays for anything. This deductible amount is $2,110 in 2013.*

For Plans K and L, after the policy holder meets his or her out-of-pocket yearly limit and their yearly Part B deductible ($147 in 2013), the Medigap policy will pay 100% of covered services for the remainder of the calendar year.

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.*

As you can see, unlike Medicare Advantage plans, Medigap plans don't come in infinite varieties. There are only these 10, as of the writing of this book.

If you're noticing that several letters are skipped, that's because some plans get phased out from time to time. If you are already enrolled in one of these Medigap plans before it's no longer offered, you can often keep that plan if your insurance provider is still willing to offer it.

This might not always be the case, but where it is, if you prefer a certain plan over the others, it might behoove you to sign up for it sooner, rather than later in case it's later canceled, you can get grandfathered in – even if you might not need all those benefits just yet. That said, getting grandfathered into canceled Medigap plans might not always be available.

How it Works

These Medigap plans can only be paired with Original Medicare.

Most Medicare beneficiaries will follow of these two tracks to get the medical coverage they need in a way that suits them best:

Part A + Part B + Part D + Medigap	**Medicare Advantage** + Part D (sometimes)

This looks a little more complicated than it really is.

Many of us are accustomed to the employer-sponsored group insurance plans we had during our working years. These plans included a lot of different elements all rolled together.

With Medicare, they've broken each element out into its own section.

While heavily dictated by Medicare, Medigap policies are sold by private insurance companies.

Here's how it works: There is a set of standardized Medigap policies that offer the same perks everywhere. There are laws saying that if you're an insurance company and you want to offer a Medigap policy, the ones you offer need to follow a strict outline.

Insurance companies can pick and choose which Medigap policies to offer, but when they offer them, they can't go off-script – unlike Medicare Advantage plans. That means that if an insurance carrier wants to sell Medigap plan F policies, for example, their plan F policy must match how Medicare has outlined Plan F.

Rules for Private Insurance Companies Providing Medigap Plans

Insurance companies wanting to sell any Medigap policy must offer:

- Plan A, and,
- Plan C *or* F

If the company wishes, they can offer both plans C and F, but they don't have to. Having satisfied these two conditions, the insurance company can then offer whatever other plans they want.

Insurance companies are also able to choose the premiums they charge for each policy. So, while offering a plan A, for example, all insurance carriers will need to cover the Medicare Part A hospital coinsurance, the Part B coinsurance, the first 3 pints of blood, and Part A hospice coinsurance. One carrier might charge a $150 premium per month, while another charges a $200 premium per month.

It's important for you, as the purchaser, to shop around and find the best prices for any given plan, keeping in mind that, in many cases, that will be the only difference in plan prices offered by different companies.

Don't pay more than you have to!

Can I have a Medigap plan and a Medicare Advantage plan at the same time?

No. Medicare Advantage and Medicare Supplement plans don't work together; in fact, you cannot be sold and use a Medigap plan if you enroll in a Medicare Advantage plan. And your Medigap policy can't be used to pay your Medicare Advantage plan co-payments, deductibles or premiums.

Are There Any Penalties Associated with Delaying Medigap?

You must be enrolled in Part B before you can be enrolled in a Medigap plan – but does delaying Part B have a negative impact on getting a Medigap plan? Do the Guaranteed Issue Rights still apply if you're applying for Part B say… during a General Enrollment Period?

Guaranteed Issue Rights

As you may know, in the past, having a pre-existing condition could often mean that you were either denied insurance coverage or it would be offered to you at a higher price.

Often, that may still be the case when it comes to Medigap policies, but if you are on top of things and apply early, you have certain rights to be able to purchase a Medigap policy regardless of your health.

Legally, if you are in one of the following situations, an insurer cannot refuse to sell you the policy.

If Your Medicare Advantage Plan No Longer Serves Your Area

This could be because you moved, because your plan stopped providing care in your area, or because your carrier is withdrawing from Medicare.

Whichever the case, you had a Medicare Advantage plan and now it's no longer available where you are.

In this situation, you have the right to switch to Original Medicare and purchase an accompanying Medigap plan – if you so wish. In that case, you may choose from plans A, B, C, F, K, or L, according to your preference.

In order to take advantage of this opportunity, you must enroll in Original Medicare + your Medigap policy as early as 60 calendar days before your Medicare coverage ends, but no later than 63 calendar days after it ends.

Note that while this is your enrollment period, your Medigap coverage can't actually begin until your Medicare Advantage coverage ends. You cannot have both at the same time.

Your secondary employer, COBRA, retiree, or union coverage is ending.

This applies to cases when you have Original Medicare and a secondary plan that pays the excess of your Medicare costs. In other words, you have double coverage.

People who have this double coverage understandably probably don't want to and probably don't have a need to get a Medigap plan.

Then, when that secondary coverage ends, all those extra benefits go away with it. At that point, it may make sense for you in your situation to purchase a Medigap plan. This guaranteed issue right [find out if these are supposed to be capitalized] allows you to do that.

As in the last case, you aren't guaranteed any Medigap plan, but you are guaranteed your pick of plans A, B, C, F, K, or L, if they're available in your area.

If you have COBRA coverage, you have your choice of purchasing a Medigap plan right away or waiting until your COBRA coverage ends.

You have until 63 calendar days past these 3 milestones to sign up for your Medigap plan:

- Date the coverage ends
- Date on the notice explaining that your coverage is ending (if you get one)
- Date on a claim denial (if this is the only notice you have that coverage is ending).

CONCLUSION

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You have a robust resource available to you in Medicare, one that you've paid into all your working life. Don't just sign up for it, embrace it and structure it in such a way that you are using it for all it was intended for – transitioning from your employer-provided healthcare coverage into retirement – assisting you with your medical needs as you grow older.

The mission for this book is to equip you with the knowledge and understanding required and to explain your options so you can make a smooth transition into Medicare and feel confident that you have made a good decision. At the very least, you have a more concise list of questions you need answered.

Here is a good place to get started:

1) Don't wait, start thinking about this now, inquiring and planning.

2) Don't miss important dates – everything from your initial enrollment period to checking your coverage every year to see if your needs have changed, and if you still have the best coverage for you and your unique situation.

3) Make your choices based on your potential future health care and drug needs.

4) Plan for longevity – you could live another 30 to 40 years, or even more, after turning age 65!

Finally, there is no shortage of information available to you on Medicare coverage. The key is to find the information that is most accurate, up-to-date, while still being applicable to you and your own unique situation. We have found that going directly to Medicare – **visiting Medicare.gov or calling them at 1-800-MEDICARE (1-800-633-4227)** – with any specific questions is very useful.

MEDICARE.GOV DEFINITIONS

Assignment - An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

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

Coinsurance - An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage - Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Critical access hospital - A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial care - Nonskilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible - The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Demonstrations - Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually only operate for a limited time, for a specific group of people, and in specific areas.

Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. This is also called a drug list.

Inpatient rehabilitation facility - A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution - For the purposes of this publication, an institution is a facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, like an assisted living facility or group home, aren't considered institutions for this purpose.

Lifetime reserve days - In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care - Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Long-term care hospital - Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically necessary - Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare-approved amount - In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid.

It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan - Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs.

Medicare plan - Refers to any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services - 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).

Primary care doctor - The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Primary care practitioner - A doctor who has a primary specialty in family medicine, internal medicine, geriatric medicine, or pediatric medicine; or a nurse practitioner, clinical nurse specialist, or physician assistant.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service area - A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled nursing facility (SNF) care - Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility.

The A B Cs & Ds of Navigating Medicare Today!

If you or a loved one is eligible for Medicare, you need to know about the services, benefits, changes, limitations and choices, current right now, and vital for your future.

- **Are you about to turn 65?**
  What you need to know before you sign up for Medicare
- **Concerned about being hit hard with prescription drug costs?**
- **Don't skip preventative care!**
  But don't pay more than you have to, either
- **Do you think you want to make a change? You can!**
  When and How – find out inside
- **Questions?**
  A directory of resources is included