

The RedShirt's Guide to Medicare



"Medicare can be complicated. But, we're here to make it easier—by answering questions and reviewing all your options."

Paul

Independent Health RedShirt®



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When you enroll in a Medicare Advantage plan, you can request to receive an annual contract, also called Evidence of Coverage (EOC). If you enroll in Original Medicare, the "Medicare & You" handbook is your contract. Members will need to enroll in Part A and purchase Part B of Original Medicare to enroll in a Medicare Advantage plan. You will receive a copy of the "Medicare & You" handbook if you are enrolled in a Medicare Advantage plan. See your actual member contract for details.



We're here to make Medicare easier.

Everybody likes having choices, but sometimes, having an abundance of options can be overwhelming. That's exactly what makes choosing a Medicare plan so complicated. But, with a little research, it's much easier to make the right decisions for your health and budget.

Our RedShirtsSM designed this booklet to help you understand the details of Medicare so you'll be prepared when the time comes for you to decide on a plan. You'll learn about the different parts of Medicare, your share of costs for coverage, enrollment deadlines, tips for choosing a plan and much more. There's also a glossary of terms and a list of resources where you can get even more information—both online and in person.

We're always ready to help. Speak with a RedShirt[®] today.

(716) 635-4900 or 1-800-958-4405 (TTY: 711)

October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.

April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

www.IndependentHealth.com/Medicare

medicarehelp@IndependentHealth.com

Five Things You Need to Know About Medicare

1

Eligibility requirements

- You are age 65 or older, have a qualifying disability or experience another special situation.
- You are a U.S. citizen or legal resident (for at least five consecutive years).

2

You have two Medicare options

There are only two distinct ways to receive Medicare:

- Original Medicare – Parts A and B
- Medicare Advantage plan – Part C

However, within these two options you have many choices: prescription drug coverage (Part D), supplemental coverage and more. To decide which is right for you takes time and a little homework.

3

Timing is crucial

You can sign up for Original Medicare or a Medicare Advantage plan three months before you turn 65, during your birthday month and three months after. If you have a qualifying disability, contact the Social Security Administration (1-800-772-1213, TTY 1-800-325-0778, Monday – Friday, 7:00 a.m. – 7:00 p.m.) for your enrollment timeframe. If you wait, you could pay more for coverage. If you continue to work, additional rules may apply.

4

Medicare doesn't cover everything

It's important to know that Medicare doesn't cover all of your health care expenses. You may have copays, deductibles, coinsurances and other payments for both Original Medicare and a Medicare Advantage plan. Also, Original Medicare does not include prescription Part D drug coverage, and there will be other gaps in coverage that you may need to cover with additional insurance.

5

Your plan choices are not permanent

If your needs change, you have an opportunity each year to change plans.

Preparing for Your Medicare Coverage

There are a few things to take care of before you can enroll in Medicare. If you're already drawing your Social Security benefits, and you'll be turning 65, the Social Security Administration will automatically enroll you in Parts A and B. If you are not drawing these benefits, you need to enroll yourself either online or at your local Social Security office. You also need to decide what to do with your current health care coverage, if you have it.

Social Security, Medicare and you

The Social Security Administration:

- Handles most of the paperwork for joining Medicare.
- Will automatically enroll you in Medicare Parts A and B if you're drawing Social Security benefits when you turn 65, and determine your premium costs.
- Will determine if you're eligible for extra help with the cost of Medicare coverage.
- NOTE: If you worked for the railroad, contact the Railroad Retirement Board to sign up. (1-877-772-5772, TTY 1-312-751-4701, Monday – Friday, 9:00 a.m. – 3:30 p.m. CST)

Current health care coverage

Before making any decisions about Medicare coverage, it is important to look at your current health care coverage. If you're receiving coverage from an employer or union, it is important to assess whether or not you want to continue receiving that coverage, or if it would be better to opt out of that coverage and select a Medicare plan.

Paying Your Share of Medicare

No matter what type of Medicare plan you choose, you will have to pay for part of the coverage. When shopping for Medicare, it's important to consider all of these types of payments, as they vary widely from plan to plan. Otherwise, you may end up paying much more than you expected.

Terms to learn:

Coinsurance Splitting health care costs based on a percentage. For example, with Original Medicare, Medicare might pay 80% of a service, while you would pay 20% of the Medicare-approved amount. Your out-of-pocket cost will differ based on the total cost of service.

Copayment A fixed amount, for example \$10 or \$20, paid for a specific service or product, like a doctor visit or prescription drug.

Deductible A pre-set amount of money that the Medicare recipient typically pays before Medicare or a private insurance company will start covering costs.

Premium The periodic payment to Medicare or an insurance company for health care and/or prescription drug coverage. It is usually a monthly payment.

Your Medicare Options

Original Medicare (Parts A and B)

If you choose Original Medicare, Parts A and B, you may decide to add on a stand-alone Part D plan for prescription drug coverage and/or Medigap for costs not covered by Parts A and B. Part D and Medigap are available through private insurance companies.



Part A Helps cover the cost of inpatient hospital stays, skilled nursing facilities, hospice care and some home health care services. There is no premium for most people.



Part B Helps cover doctor visits, outpatient care and some home health services. Most people pay a premium based on income.



Stand-Alone Part D (PDP) Helps cover the cost of outpatient prescription drugs. There are monthly premiums paid to a private insurance company. NOTE: Enroll when you first become eligible or you may be subject to penalties later.



Medigap There are several standardized plans available through private insurance companies that help cover costs not covered by Parts A and B. You cannot have a Medigap policy and a Medicare Advantage plan at the same time.

More choices to make

While there are two main “paths” you can take when you choose Medicare coverage, there are many choices within those paths. Even within these options there are many choices, which is why it is so important to do your research and learn which plan would best suit your unique needs.



Medicare Advantage Plan (Part C)

If you choose a Medicare Advantage plan through a private insurance company, you have coverage for the same services covered by Parts A and B, but your cost sharing will differ from Original Medicare. Additional benefits may also be included in the plan.



Part C Medicare Advantage plan—Helps cover inpatient hospital care and outpatient care, such as doctor visits, preventive health screenings and other services. (Part C covers everything covered by Original Medicare Parts A and B.)



Part D Outpatient prescription drug coverage is included in most Medicare Advantage plans. NOTE: You must enroll when you first become eligible or you may be subject to a penalty later.



Additional benefits Some plans may include routine vision, routine hearing, routine and preventive dental, wellness programs and more as part of the plan.

Supplemental benefits Some plans may include additional coverage, such as dental, for a fee. You must elect to have this coverage.

More choices to make

A Medicare Advantage plan, the other main “path,” offers many options within options as well. Every insurance company offering this type of plan has different costs and benefits, so you need to investigate exactly what each plan covers. Remember that Part C covers all of the services covered by Parts A and B.





“Understanding how Parts A and B work is important so you don’t have to pay more in the long run.”

Gerald

Medicare Part A



Medicare Part A covers:

- Inpatient hospital stays
- Skilled nursing facilities
- Hospice
- Some other skilled care

The details:

- Semi-private room
- Hospital meals
- Skilled nursing services
- Special unit care (for example, Intensive Care)
- Inpatient hospital services
- Operating and recovery room services
- Some blood transfusions
- Inpatient rehab services (such as physical therapy)
- Skilled health care in your home
- Hospice care for the terminally ill
- And other services

Main points:

- Helps cover care received in hospitals and critical access hospitals, as well as skilled nursing facilities, some home health care services and hospice.
- Available at no cost to people who have worked, or whose spouse has worked, for at least 10 years and have paid Medicare taxes through their employer(s). Otherwise, there is a premium for this coverage.

Providers:

- You can see any qualified provider in the U.S. who is approved by Medicare and is accepting new patients.

Coverage limits:

- If you are in the hospital for more than 90 days at one time, Medicare Part A limits the number of days it will help cover.
- Number of days in a skilled nursing facility is limited.
- Unlimited number of skilled home health care or hospice care visits, but you must meet certain conditions.

Not covered:

- Personal costs in the hospital—for example, telephone calls or television.
- Custodial care—help with daily activities like eating, bathing and dressing. (This is because custodial care is not skilled medical care.)
- Long-term care, like nursing home care. (There is a difference between a skilled nursing facility and long-term care. Please refer to the glossary for full definitions.)
- Most hospital stays outside the country.

Costs:

Your premium:

- No cost—if you or your spouse have made payroll contributions to Social Security for at least 10 years (40 quarters).
- Monthly premium—if you and your spouse have not contributed to Social Security.

NOTE: If you do not enroll in Part A when you become eligible for Medicare (and you must pay a premium for Part A), your premium could be higher later.

Your deductible:

- Before Part A begins paying a share of your costs, you must first pay a deductible. You'll pay this deductible for each hospital stay, subject to certain limits.

Your copay:

- For hospital stays, your deductible covers days 1 through 60. After that, you'll have a daily copay that varies depending on length of stay.
- In a skilled nursing facility, you'll have a copay per day for days 21 through 100. (Days 1 through 20 have no copay.)

Enrolling in Part A

When:

- You are able to sign up for Medicare Part A three months before you turn 65, during your birthday month and three months after. You can enroll later, but only at certain times of the year, unless you qualify for an exception. (A late penalty may apply.)
- If you sign up at the start of your initial enrollment period, your coverage will begin on the first day of the month you become eligible (your birthday month). If your birthday is the first of the month, you will get coverage the month before your birthday.
- If you have a qualifying disability, you can enroll after you have received disability benefits for 24 months.

How:

- If you are already receiving Social Security benefits when you become eligible, you'll be automatically enrolled in Part A.
- If you're not receiving Social Security benefits, you need to sign up for Part A at your local Social Security office.

Coverage denial:

- You cannot be refused Part A because of your medical history or a pre-existing illness.

Annual renewal:

- Part A coverage renews automatically every year.



“At first, I wasn’t sure what Original Medicare covered, or that I even had other options to think about.”

Julia

Medicare Part B



Medicare Part B covers:

- Doctor’s office visits
- Outpatient care
- Some home health services
- Some other medical services

The details:

- Doctor’s office visits (including annual physical)
- Ambulatory surgery center services
- Outpatient medical services
- Some preventive care (for example, flu shots)
- Clinical laboratory services (blood tests, urinalysis, etc.)
- X-rays, MRIs, CT scans, EKGs and some other diagnostic tests
- Some preventive screenings, such as colorectal, prostate cancer screenings and mammograms
- Durable medical equipment for home use (oxygen, wheelchairs, walkers, etc.)
- Emergency room services
- Skilled health care at home on a part-time basis
- Mental health care (as an outpatient)
- And other services

Main points:

- Helps cover care received in doctor's offices, outpatient care, as well as other medical services, like preventive services, that Part A doesn't cover.
- There is a monthly premium for Part B coverage, which is set annually by CMS based on income.
- Once you meet your deductible, Part B usually covers 80% of the cost of a service.
- You may sign up for Part B during the seven-month period that includes the three months before your 65th birthday, your birthday month and three months after.

Providers:

- You can see any qualified provider in the U.S. who is approved by Medicare and is accepting new patients.

Coverage limits:

- Generally, as long as your care is medically necessary, Part B will not limit the number of services you receive. However, physical, occupational and speech therapy visits are limited per year.
- Preventive care/screenings are limited to specific intervals.

Not covered:

- Care for routine vision, routine hearing and routine and preventive dental—except in very limited situations.
- Care outside the United States—except in very limited situations.
- Custodial care—help with daily activities like eating, bathing and dressing.

Costs:

Your premium (premium amounts are set by CMS and change every year).

- Based on your annual income.
- Can be automatically deducted from your Social Security benefits.
- If you do not collect a Social Security check, you will be billed quarterly for your premium.
- Penalty—you could pay more (up to 10%) if you don't sign up for Part B when you first become eligible.

Your deductible:

- Before Part B begins paying a share of your costs, you must first pay an annual deductible.

Your copay:

- Outpatient hospital services copays can range from a few dollars to well over \$1,000.

Your coinsurance:

- Part B covers approximately 80% of your care, meaning that your coinsurance is about 20% (after you pay your deductible).
- For outpatient mental health, your coinsurance can be higher than 20% (for example, 40%).

Enrolling in Part B

When:

- You are able to sign up for Medicare Part B three months before you turn 65, during your birthday month and three months after. You can enroll later, but only at certain times of the year, unless you qualify for an exception.
- If you sign up at the start of your initial enrollment period, generally, your coverage will begin on the first day of the month you become eligible (your birthday month).
- If you have a qualifying disability, your initial enrollment period (established by the Social Security Administration) depends on the date your disability or treatment began.

How:

- If you are already receiving Social Security benefits when you become eligible, you'll be automatically enrolled in Part B. If you don't want Part B, you need to refuse it by contacting your local Social Security office.
- If you're not receiving Social Security benefits, you need to sign up for Part B by contacting your local Social Security office.

Coverage denial:

- You cannot be refused Part B because of your medical history or a pre-existing illness.

Annual renewal:

- Part B coverage renews automatically every year, as long as you pay your premium.

Some terms you should know:

Accepting assignment When doctors agree to the Medicare-approved amount as full payment, this means your share is limited to a percentage of the Medicare-approved amount.

Excess charges If a doctor does not agree to the Medicare-approved amount, Medicare reduces the amount they pay by 5%—then your doctor can charge you up to 15% more of the reduced amount—also called “balance billing.” If your doctor accepts Medicare, they will not be allowed to bill you these excess charges.

Medicare-approved amount This is the amount of money Medicare has decided Part B will cover. Providers in the Medicare network cannot balance bill. (See “Excess charges” above.)



"I met with a RedShirt®, and they reviewed every detail of the Medicare Advantage plans with me so I could make the best decision."

Nadine

Medicare Part C



Medicare Part C (Medicare Advantage plan) covers:

- All services included in Parts A and B
- Most plans include prescription drug coverage (Part D)
- May offer extra coverage like routine vision, routine hearing, routine and preventive dental and health and wellness programs

Main points:

- Medicare Advantage plans are private health plans that usually cover more services and have lower out-of-pocket costs than Original Medicare. Every insurance company that offers these plans has a contract with the federal government that is renewed annually.
- A Medicare Advantage plan takes over for Medicare and is responsible for paying your claims. You are responsible for paying your member deductibles (if applicable), copays and coinsurances.
- Plans that include prescription drug coverage allow you to get both your health care and prescription drug coverage from the same private insurance company.
- One important benefit of Medicare Advantage plans is that they cap the amount of your out-of-pocket costs—Original Medicare does not do this. This allows you to budget more efficiently than with Original Medicare, which has no limit on how much you may be responsible for.
 - For example, let's say you have Original Medicare and need to spend an extensive amount of time in the hospital. You would be responsible for the Part A deductible, which changes each year.
 - But, if you do reach this out-of-pocket limit with most Medicare Advantage plans, your copay for Medicare-covered medical services would then be \$0 for the rest of the calendar year.

Providers:

- The providers you are able to see vary by plan.
- Coordinated care (i.e., HMO plan)—in this type of plan, you have a primary care physician who helps manage the care you receive from specialists and hospitals.
- Other plans (Preferred Provider Organization [PPO])—in this type of plan, you can visit doctors, hospitals and providers inside and outside of the network, as long as it is medically necessary.

Coverage limits:

- Vary by plan. See plan for details.

Costs:

NOTE: Some people may pay an extra amount based on their yearly income.

Your premium:

- Even if you have a Medicare Advantage plan, you must pay your Part B premium (unless others pay it on your behalf), your Part A premium (if you have one), any late enrollment penalties (if applicable) and income related adjustments (if applicable).
- Premiums vary widely by plan.
- Premiums and other plan terms may change every year on January 1.

Your deductible (if applicable):

- The amount you must pay of the full cost for medical services before your plan begins to pay its share. Varies by plan. See plan for details.

Your copay:

- A fixed amount you pay each time to receive certain medical services. Varies by plan. See plan for details.

Your coinsurance:

- A percentage you pay of the total cost of certain medical services. Varies by plan. See plan for details.

Enrolling in Part C (Medicare Advantage plan)

When:

- You must be enrolled in Parts A and B.
- You are able to enroll in Medicare Part C three months before you turn 65, during your birthday month and three months after. If you have a disability, you can join during the three months before to the three months after your 25th month of disability.
- You can enroll later, but only at certain times of the year, unless you qualify for an exception.
- If you sign up at the start of your initial enrollment period, generally, your coverage will begin on the first day of the month you become eligible (your birthday month).

How:

- Contact the insurance plan you wish to join and ask about their enrollment process. All plans allow you to enroll online, by phone, by mail, in person or at www.medicare.gov.

Coverage denial:

- As long as you meet the eligibility criteria, you cannot be denied enrollment.
- Special Needs Plans—these have eligibility rules you must meet. Ask the insurance company for details.

Annual renewal:

- Medicare Advantage plan coverage renews automatically every year, as long as you pay your premium. You have the option to stay in or change plans every year—generally, in the fall during the annual enrollment period.

Types of Medicare Advantage plans

There are a variety of Medicare Advantage plans available to meet individual needs, including the following coordinated care plans:

Health Maintenance Organization (HMO) Plan

- Must use doctors who belong to the plan.
- Must go to hospitals within the network.
- If you go outside the network, you have to pay for your own care (except for emergency, urgent services and renal dialysis, which are covered nationwide).
- You will be required to choose a primary care physician.
- Primary care physician may manage care received from specialists.
- You may need a referral from your primary care physician to see a specialist.

Preferred Provider Organization (PPO) Plan*

- More likely to have freedom to choose your doctor outside the network.
- Typically don't need a referral to see a specialist.
- Can see doctors outside the network who participate with Original Medicare for a higher share of the cost.

*Out-of-network/non-contracted providers are under no obligation to treat Independent Health's members, except in emergency situations. For a decision about whether or not we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Point of Service (POS) Plan

- Allows members to visit doctors and hospitals outside of the network—typically with a higher copay or coinsurance.
- Some plans do not require referrals for specialty services.
- May have a limit on out-of-network covered services.

Special Needs Plan (SNP)

- Coordinated care plans designed for people with special needs.
- Combines hospital, doctor visits, outpatient care and prescription drugs in a single plan.
- Usually includes well-coordinated care and may offer a manager or nurse practitioner as an advocate for the member.
- Examples of people who may be eligible for SNP:
 - People in nursing homes or long-term care facilities
 - People eligible for Medicare and Medicaid (Dual Eligible Special Needs Plans)
 - People with select chronic diseases

NOTE: There are other Medicare Advantage plan options available. For more information, visit www.medicare.gov.



Selecting the Right Medicare Advantage Plan for You

Following a few simple steps can make shopping for a Medicare Advantage plan much easier:

1. Contact the plans you're interested in, and start doing your research online or in person.
2. Look at the premium, if any.
3. Estimate your total cost sharing for the services you need.
4. Find a plan where the maximum out-of-pocket expenses match your budget.
5. Determine whether or not the plan includes the providers you want to see.
6. See what medications their Part D plan covers.
7. Use a plan's star ratings to see how it compares to other options available in your area.
8. Give yourself plenty of time to get all this information and make your decision. Remember, the enrollment periods are very specific, and you could pay more or have fewer choices if you wait.
9. See which plans are available in your area. For a list, go to www.medicare.gov, call the Medicare Helpline at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048 (available 24 hours a day, seven days a week), or see the "Medicare & You" handbook.



“Learning about the ‘doughnut hole’ associated with Part D really helped me plan ahead.”

Joe

Medicare Part D



Medicare Part D covers:

- Prescription drugs

Two ways to get Part D:

Stand-Alone Part D Plan or Prescription Drug Plan (PDP)

- Add drug coverage to Original Medicare, a Medicare Private Fee-for-Service (PFFS) plan or a Medigap plan.

Medicare Advantage Plan with Prescription Drug Coverage (MA-PD)

- You get all of your Part A and Part B coverage and prescription drug coverage (Part D) through these plans.

Main points:

- Offered through private insurance companies, which negotiate to get the best possible rates.
- Helps lower the cost of your prescription drugs and could prevent costs from increasing later.
- This is optional coverage and plans vary widely.
- There are often monthly premiums paid to a private insurance company.
- Enroll when you first become eligible or you may pay a penalty later, unless you have creditable coverage.
- Drugs covered vary widely. Check the formulary of each plan. (A formulary is the list of medications covered by a plan.)

Pharmacies:

- Some plans limit your choice of pharmacy by geographic area.
- Some plans may have preferred pharmacies, which means you may pay a lower copay for your prescription drugs.
- If you travel often, be sure to choose a plan that offers nationwide coverage.
- Some plans offer mail-order services, so you can have your prescriptions mailed right to your door.

Coverage limits:

- There are different levels, or stages, of cost sharing until you have spent a certain amount, determined annually.
- During one stage, called a “coverage gap” or “doughnut hole,” you will be responsible for some of the full cost of your medications. You’ll receive a discount on both brand name and generic drugs.
- True Out-of-Pocket expenses (TrOOP)—the amount you may pay (or may be paid by someone else on your behalf) in deductibles, copays, coinsurances and payments toward the cost of your prescriptions.
- Once you pass the coverage gap and your TrOOP expenses have reached your plan limit, you are eligible for what is known as “catastrophic coverage.” Once reaching the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under an enhanced benefit.

NOTE: Part D drugs purchased outside of the U.S. are never covered.

Not covered:

- This varies widely by plan, and you need to be sure all the prescriptions you use are covered. This is very specific, so be sure to check the name of each drug, as some plans will cover one brand but not another.
- Remember that throughout the year, your share of drug costs may change depending on how much you have spent.

Costs:

NOTE: Some people may pay an extra amount based on their yearly income.

Your premium:

- Even if you have a Medicare Advantage plan, you must pay your Part B premium (unless others pay it on your behalf), your Part A premium (if you have one), any late enrollment penalties (if applicable) and income-related adjustments (if applicable).
- Premiums vary widely by plan.
- Premiums and other plan terms may change every year on January 1.

Your deductible (if applicable):

- The amount you pay for drugs before our plan begins to pay its share. Varies by plan. See plan for details.

Your copay:

- Most plans charge a copay each time you fill your prescription. Varies by plan. See plan for details.

Your coinsurance:

- Some drug plans charge a percentage of the cost of your prescription. Varies by plan. See plan for details.

Enrolling in Part D

When:

- You are able to enroll in Medicare Part D three months before you turn 65, during your birthday month and three months after.
- For the most comprehensive coverage, you should enroll in Parts A and B.
- You can enroll later, but only at certain times of the year, unless you qualify for an exception.
- If you have a qualifying disability, you are eligible when you qualify for Parts A or B.

How:

- Contact the insurance plan you wish to join and ask about their enrollment process. You cannot enroll in Part D through the Social Security Administration.

Coverage denial:

- As long as you have enrolled in Parts A or B, you cannot be denied.
- You can only join one plan at a time—either one of the stand-alone prescription drug plans or a Medicare Advantage plan with drug coverage. (See “Two ways to get Part D,” page 17.) If you enroll in more than one plan, you will ultimately be enrolled in the plan you joined last.

Annual renewal:

- Medicare Part D coverage renews automatically every year, as long as you pay your premium. You have the option to stay in or change plans every year. Your plan will notify you of any changes.



Choosing the Right Part D Plan for You

Following a few simple steps can make shopping for a Part D plan much easier:

1. Contact the plans you're interested in, and start doing your research online or in person.
2. Look at the premium.
3. Make sure all your prescriptions are in the plan's formulary. (A formulary is a list of the drugs a plan covers and what tier they're in, which determines their cost.)
4. If one of your drugs is not in the formulary of the plan you want to choose, talk to your doctor. You can try other drugs, or the plan may be able to make an exception for you.
5. Decide if you want to use mail-order service for your prescriptions, as not every plan covers this.
6. Estimate your total out-of-pocket expenses for the drugs you will need.
7. Find a plan with cost sharing expenses that best match your budget.
8. Use a plan's star ratings to see how it compares to other options available in your area.
9. Give yourself plenty of time to get all this information and make your decision.
10. See which plans are available in your area. For a list, go to www.medicare.gov, call the Medicare Helpline at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048 (available 24 hours a day, seven days a week) or see the "Medicare & You" handbook.

Remember, the enrollment periods are very specific, and you could pay more or have fewer choices if you wait.



“When it comes to Medigap policies, it’s so important to do your homework. Insurance companies can charge differently for the same services.”

Rick

Medigap



Medigap covers:

- Some of the other costs not covered by Medicare Parts A and B

The details:

- Part A deductibles (select plans)
- Coinsurance and providers’ excess charges (select plans)
- Blood transfusions
- Cost of additional hospital days after Part A stops paying
- Hospital and skilled nursing facility coinsurance
- Some preventive care
- Emergency medical benefits in foreign countries (select plans)
- NOTE: You cannot have Medigap and a Medicare Advantage plan at the same time.

Main points:

- Medicare supplement policies, also called Medigap, cover some or all of the expenses not covered by Parts A and B.
- There are 9 standardized plans.
- Medigap is available through private insurance companies, but the government defines the standards.
- Prices vary widely by company, even for identical coverage.
- Insurers use a variety of methods to set the price on their policies. This is called “rating.”

Coverage limits:

- Medigap policies provide 365 additional days of hospital care during your lifetime. These days are beyond the reserve offered by Medicare.
- You are not covered for days in a skilled nursing facility beyond the 100 days covered by Part A.
- Generally, you are not covered outside the United States; however, some policies do offer emergency care coverage in foreign countries.

Not covered:

- Long-term care, like nursing home care.
- Routine vision exams and eyeglasses, routine hearing care and hearing aids, most routine and preventive dental services and most wellness services.
- Private-duty nursing.

Costs:

Your premium:

- Varies by plan. See plan for details.
- Usually the more coverage, the higher the premium.
- Medigap premiums may go up, even after you’ve bought that specific policy. They can change monthly.

Your deductible:

- Some plans offer a high deductible—once you meet this, the plan will begin to cover your expenses.

Your copay:

- Some plans charge copays for doctor and emergency room visits.

Your coinsurance:

- Some plans split costs between you and them.

Enrolling in Medigap

When:

- You can apply when you turn 65 and have enrolled in Parts A and B.
- You have a six-month period in which you can enroll—during this time, the insurer cannot consider your medical history or current health as a basis for your premium.
- If you had creditable coverage, a pre-existing condition clause will not apply. If not, the insurer may make you wait for six months before your coverage begins.
- If you have a qualifying disability, you are eligible when you qualify for Parts A and B.

How:

- Contact the insurance plan you wish to join and ask about their enrollment process.

Coverage denial:

- If you miss the six-month enrollment period, then you can be denied.
- You may still have the right to coverage if you miss this period; however, these are limited situations.

Annual renewal:

- Medigap policies renew automatically every year, as long as you pay your premium. You have the option to stay in or change Medigap plans monthly.



Choosing the right Medigap policy for you

Following a few simple steps can make shopping for a Medigap policy much easier:

1. Visit www.medicare.gov for Medigap policy and premium information, or call your State Health Insurance Assistance Program (SHIP) to see which plans are available to you.
2. Review the individual Medigap plans to see which policy best meets your needs.
3. Give yourself plenty of time to get all this information and make your decision.

Remember, the enrollment periods are very specific, and you could pay more or have fewer choices if you wait.



"I recorded all my health care expenses from the last three years. It made it easy to select a plan I could afford that included the benefits I needed."

Michelle

Time to Enroll

Choosing a Plan

The best way to decide which Medicare plan fits your needs is by doing research and asking questions. There are many resources available, from the Medicare website to your friends and family. You can never know too much about Medicare, as it's a really big decision, and there are many things to consider.

Some topics to think about:

- Type and number of prescription drugs you use and how much they cost.
- Providers you see regularly and the conditions you see them for.
- The number of times you travel and whether you travel out of the country.
- Whether you require the flexibility to see providers outside a network.
- Your health care costs from previous years.
- Whether or not you will need financial help to pay for Medicare.

Once you figure out your health care priorities, it will be much easier to decide what would work best for you—medically and financially. For more help, check out www.medicare.gov and the resources listed in the back of this booklet. We have also included a helpful worksheet for you to figure out your annual health care expenses, so you can see how much you spend and what type of plan would be right for you. (See page 40.)

Star Ratings*

Star ratings, compiled annually by Medicare, are an unbiased way to compare Medicare Advantage plans based on quality, value and performance. Health and pharmacy services are rated together through information gathered from clinicians, member surveys and other trusted sources.

Stars for each plan show how well the plan performs cumulatively on a set of quality measures, designed to help you objectively choose a plan. Ratings are based on a 5-star scale, with one star meaning “poor” quality ranging up to five stars for “excellent” quality. 5-star rated plans have year-round enrollment. Visit www.medicare.gov to find the star ratings of the Medicare plans you’re interested in.

*Every year, Medicare evaluates plans based on a 5-star rating system.

Six Things to Consider When Choosing a Medicare Advantage Plan

1. **Locally based service**—See if your plan has local representatives and convenient locations where you can get your questions answered.
2. **In-depth knowledge**—Make sure the representatives you’re meeting with have a deep understanding of all of your options, so you feel assured they can help you make an educated health decision.
3. **A strong network**—With some health insurers, provider participation varies by plan. It’s important to verify that your doctors are “in-network” by reviewing the plan’s provider directory.
4. **Pharmacy coverage**—Each health plan has its own relationship with pharmacies, so it’s best to check if your local pharmacy works with your health plan.
5. **Added value**—Not all Medicare Advantage plans offer extra benefits like vision, dental and fitness. Be sure all of these are included in your coverage to maximize the total value of your plan.
6. **Quality matters**—Look for the health plan’s CMS ratings—an unbiased way to compare Medicare Advantage plans based on quality, value and performance.

Getting Financial Help

If you think you may need help covering your share of Medicare, there are several programs available to you. Even if you're not sure if you qualify, you should still sign up, as less than half of people who are eligible sign up for these benefits. Don't miss out by not signing up!

- Medicaid: Helps pay costs not covered by Parts A and B and may include additional coverage like eye care and non-emergency transportation to doctors' appointments.
- Programs of All-Inclusive Care for the Elderly (PACE): A combination of medical, social and long-term care for elderly people in poor health.
- Prescription drug premium assistance programs: Help pay some or even all of Part D premiums, deductibles (if applicable), copays and coinsurances.
- State Pharmaceutical Assistance Program (SPAP): Such as Elderly Pharmaceutical Insurance Coverage (EPIC) in New York State—provides assistance with your prescription drug costs.
- Extra Help/Low Income Subsidy (LIS): Based on your income, you can get help paying for prescription drugs.

Contact your local Social Security office for more information. (See "Resources" in the back of this booklet.)

How to Change Plans

It's a good idea to check your coverage annually to see if it's meeting your needs. If it's not, you're allowed to change your plan once a year. This time is called the annual enrollment period, and it usually happens in the fall. During this period, you can add, drop or change your Part D coverage. You can also join or change a Medicare Advantage plan.

The annual enrollment period is usually the only time you can change plans; however, Medigap coverage can be changed at any time. Just be sure your new policy is effective before you drop your old policy (October 15 – December 7).

There is also an open enrollment period. During this period, if a member is enrolled in a Medicare Advantage plan, they can make one plan change to a different plan or back to Original Medicare. The Medicare Advantage open enrollment period is from January 1 through March 31.

EXCEPTIONS: There are a few situations in which you can change your coverage outside of the annual enrollment/open period (for example, if you move out of the area).

If you experience any major life changes, call the Medicare Helpline at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048 (available 24 hours a day, seven days a week) for more information about timing rules.

The Medicare Enrollment Timeline

The periods for enrolling in the various Medicare parts are very specific and rigid. Right around your 65th birthday is when you need to have all your choices made, so it's best to plan well ahead of time. If you miss these windows, you may have to pay more and have fewer choices.



Part A

Seven-month period

- You can enroll three months before your 65th birthday, during your birthday month and three months after.
- If you have a qualifying disability, you can join during the three months before to the three months after your 25th month of disability.
- Part A is premium-free if you or your spouse worked the required 10 years to be eligible.
- If you are eligible for Part A but do not enroll in a Medicare plan, you will incur a late penalty.



Part B

Seven-month period

- You can enroll three months before your 65th birthday, during your birthday month and three months after.
- If you have a qualifying disability, you can join during the three months before to the three months after your 25th month of disability.
- If you enroll later, your premiums could be higher.
- There is a special enrollment period for working individuals.



Part C

(Medicare Advantage)

Seven-month period

- You can enroll three months before your 65th birthday, during your birthday month and three months after.
- If you have a qualifying disability, you can join during the three months before to the three months after your 25th month of disability.
- If you miss your initial enrollment period, you must wait until the next annual enrollment period, which usually takes place in the fall.
- Your plan can never be effective prior to the date that you are eligible for Parts A and B.
- Enrollment is never retrospective.



Part D

(and Stand-Alone PDP)

Seven-month period

- You can enroll three months before your 65th birthday, during your birthday month and three months after.
- If you miss your initial enrollment period, you must wait until the next annual enrollment period, which usually takes place in the fall—your premiums may be higher if you wait.
- If you have a qualifying disability, you are eligible when you qualify for Parts A or B.



Medigap

Six-month period

- When you enroll in Part B, you are guaranteed the right to buy a Medigap policy for six months (only available with Original Medicare, not a Medicare Advantage plan).

Frequently Asked Questions

Where do I apply for Medicare?

You can apply for Medicare benefits through the Social Security Administration. Call 1-800-772-1213, TTY 1-800-325-0778 (Monday – Friday, 7:00 a.m. – 7:00 p.m.) or visit www.ssa.gov.

I'm 62, and I have started receiving Social Security benefits. Can I also sign up for Medicare now?

In most cases, you are not eligible for Medicare until you turn 65. There are some individuals who qualify for Medicare because of disability. Please contact the Social Security Administration for questions about your Medicare effective date.

I am not currently collecting a Social Security check, and I'm 65. Am I still eligible for Medicare, and how do I pay for it?

In most cases, yes, you are eligible. Receiving Medicare benefits is not related to collecting a Social Security check. If you have not worked 10 years, you may be able to buy Part A. To pay for Part B, you will be billed quarterly. Call 1-800-772-1213, TTY 1-800-325-0778 (Monday – Friday, 7:00 a.m. – 7:00 p.m.) or visit www.ssa.gov for more information.

What happens if I'm still working at 65?

If you are still working when you become eligible for Medicare, and you have health care coverage through your employer or union, contact the benefits administrator to find out how your insurance works with Medicare and if you should enroll in Part B. It's important to review your options to ensure you won't have to pay penalties or higher premiums when you do retire.



What if I initially decline Part B but want to pick it up later?

If you don't sign up for Part B when you're first eligible for Medicare, you may have to pay a late enrollment penalty every month for as long as you have Medicare. In addition, your monthly premium may go up as much as 10% for each 12-month period that you could have had Part B, but didn't. If you have been actively working and covered by group insurance, this penalty may not apply to you. You should discuss this with your group's benefits administrator prior to turning 65, so you have plenty of time to avoid penalties.

Does my income affect how much I have to pay for Medicare?

Yes. Your income determines how much you will pay for Parts B and D.

My husband plans on retiring and enrolling in a Medicare plan when eligible at age 65. I'm 62 and have always been covered by his health care benefits. What happens when he joins Medicare?

You will not be eligible for Medicare coverage until you turn 65, so you'll need to find other health insurance coverage until then. Your husband's company may have arrangements for retirees with younger spouses. Talk to his employer about your options.

Your husband's job may offer COBRA coverage. Otherwise, you should review individual health insurance plans available in your area. Learn more about your plan options in New York State by visiting <https://nystateofhealth.ny.gov>.

Do my spouse and I have to take the same Medicare plan?

No. You can choose whichever plan meets your individual needs.

I've heard that under Original Medicare, hospital stays can include a number of different copays. How does that work?

Part A of Original Medicare helps pay for hospital stays; however, the copays differ depending on how many days you stay in the hospital:

- An initial hospital deductible, but no copay for days 1 through 60 (during each benefit period).
- A copay amount per day for days 61 through 90 (during each benefit period).
- From day 91 on, there may be a higher copay rate for each lifetime reserve day. You have a total of 60 lifetime reserve days.
- After the lifetime reserve days are used up, you are responsible for all costs.

What happens if I've retired from the railroad?

In most cases, if you're already getting benefits from the Railroad Retirement Board (RRB), you will automatically get Original Medicare (Parts A and B) when you turn 65. If you aren't getting RRB benefits yet, you will need to contact the RRB to sign up (1-877-772-5772, TTY 1-312-751-4701, Monday – Friday, 9:00 a.m. – 3:30 p.m. CST).

Which disabilities are covered by Medicare?

Most disabilities (for people aged 18 to 64) are covered by Medicare after a 25-month waiting period. Contact your local Social Security office or call 1-800-772-1213, TTY: 1-800-325-0778 (Monday – Friday, 7:00 a.m. – 7:00 p.m.) to see if you’re eligible.

I am eligible for Medicare because of a disability. What are my coverage options?

Your coverage options are the same as someone who has turned 65. However, you will not be eligible for Elderly Pharmaceutical Insurance Coverage (EPIC) until you turn 65.

My 65th birthday falls on the 1st of the month. When does my Medicare coverage begin?

Usually, your coverage begins on the first day of your birthday month (for example, if your birthday is August 11, your coverage begins August 1). However, if your birthday is on the first day of the month (for example, April 1), your coverage begins the first day of the prior month (for example, March 1).

Is nursing home care covered by Medicare?

No. Most plans do not cover this type of long-term care, so you will need to look for long-term care insurance. More information can be found at www.medicare.gov or the NYS Department of Insurance website, www.ins.state.ny.us.

What are the eligibility requirements to join a Medicare Advantage plan?

- You need to be enrolled in Parts A and B.
- You or someone on your behalf must continue to pay your Part B premium.
- You must live in the plan’s service area.

NOTE: You must enroll during the annual enrollment period or a special election period, if you qualify.

What do I need to bring to enroll in a Medicare Advantage plan?

The only thing you need is your red, white and blue Medicare card, which you should receive in the mail three months before your 65th birthday. If you don’t receive or can’t find your card, call the Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778 (Monday – Friday, 7:00 a.m. – 7:00 p.m.) or visit www.ssa.gov.

What if I'm a veteran? How am I covered?

If you are entitled to both Medicare and Veterans' benefits, you can get coverage through either program. You must decide which benefits to use every time you see a doctor or get health care. If you want your Veteran's benefits to cover a service, you must go to a Veterans' Affairs (VA) facility or get the VA to authorize services in a non-VA facility. For more information and Veterans' benefits eligibility requirements, visit www.va.gov or call your local VA office or the national VA number at 1-800-827-1000, TTY: 1-800-829-4833.

I currently have Original Medicare and a Medigap policy but was thinking of moving to a Medicare Advantage plan. Can I have a Medicare Advantage plan and a Medigap policy at the same time? If not, can I drop the Medigap policy and pick it up again at a later time?

If you decide to join a Medicare Advantage plan, you must drop the Medigap policy, as you cannot use it to pay Medicare Advantage plan copays, deductibles (if applicable) or premiums. Medigap policies can only be used with Original Medicare (Parts A and B). If you want to cancel your Medigap policy, contact your insurance company. Once you drop your Medigap policy, you will not be able to re-enroll until the next annual enrollment period.

What if I leave employer-sponsored coverage for an individual plan? Can I go back on my employer's plan?

It depends on whether or not your employer allows this. Talk to the benefits administrator at your company.

How do I know if I have creditable prescription coverage?

Once you become eligible for Medicare, your employer should notify you every year. Keep this statement for your records. Prescription coverage through the VA is considered creditable.

What are Accountable Care Organizations?

An Accountable Care Organization (ACO) is a group of doctors and other health care providers who are working together with Medicare to coordinate care and services. ACOs are designed to help doctors, facilities and providers communicate more closely about your care. Your doctor has to decide to participate in an ACO.

What are Dual Eligible Special Needs Plans?

If you are eligible for both Medicare and Medicaid, you could benefit from a Dual Eligible Special Needs Plan, or D-SNP. A D-SNP plan combines the benefits of both programs to help raise the quality of care you receive while reducing your costs.

Glossary

Accept Assignment In Original Medicare, this means a doctor or supplier agrees to accept the Medicare-approved amount as full payment. If you are in Original Medicare, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Annual Enrollment Period Specific time of the year in which you can enroll in Medicare Advantage plans and prescription drug plans. Also called "Annual Election Period."

Appeal A special kind of complaint you make if you disagree with certain kinds of decisions made by Original Medicare or by your health plan. You can appeal if you request a health care service, supply or prescription that you think you should be able to get from your health plan, or you request payment for health care you already received, and Medicare or the health plan denies the request. You can also appeal if you are already receiving coverage, and Medicare or the plan stops paying. There are specific processes your Medicare Advantage plan, other Medicare health plan, Medicare drug plan or Original Medicare must use when you ask for an appeal. (See Grievance.)

Balance Billing An additional payment made to a doctor who does not accept assignment. You may not be billed more than an additional 15% of the Medicare-approved amount.

Beneficiary The name for a person who has health care insurance through the Medicare or Medicaid program.

Benefits Administrator Person from an employer group who is responsible for delivering information about a health plan to that group.

Benefit Period A "benefit period" begins the day you go to a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient hospital care (or skilled care in an SNF) for 60 days in a row. If you go into a hospital or an SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible (if applicable) for each benefit period. There is no limit to the number of benefit periods.

Brand Name Drug A prescription drug sold under a trademarked name.

Catastrophic Coverage Once reaching the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under an enhanced benefit.

Centers for Medicare & Medicaid Services (CMS) A U.S. federal agency that oversees the Medicare program and helps states manage Medicaid programs.

Coinsurance The amount you may be required to pay for services after you pay any plan deductibles. In Original Medicare, this is a percentage of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B.

Coordination of Benefits Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called “crossover.”

Copayment The amount you pay for each medical service, like a doctor’s visit or prescription in some Medicare health and prescription drug plans. A copayment is usually a set amount you pay. For example, this could be \$10 or \$20 for a doctor’s visit or prescription.

Cost Sharing The amount you pay for health care and/or prescriptions. This amount can include copayments, coinsurance and/or deductibles.

Coverage Gap In Medicare Part D, there is a stage where you will pay most of the cost of your prescriptions. This stage falls between your initial coverage limit and catastrophic coverage. (See Catastrophic Coverage.)

Creditable Coverage (Medigap) Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy. (See Pre-Existing Conditions.)

Creditable Coverage (Pharmacy) Certain kinds of previous prescription drug coverage that meet Medicare’s minimum standards, since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.

Custodial Care Non-skilled, personal care, such as 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 care that most people do themselves, like using eye drops. In most cases, Medicare does not pay for custodial care.

Deductible The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan or other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year.

Defined Standard Benefit Plan The plan that Congress wrote for Part D. The Standard Benefit Plan is the minimum allowable plan to be offered and still be considered creditable coverage. (See Creditable Coverage.)

Drug List A list of prescription drugs covered by a plan. Also called a “formulary.”

Dual Eligible Special Needs Plans This type of plan, often abbreviated as D-SNP, is available only to people who are entitled to both Medicare and Medicaid. If you are eligible for each of these programs, you can receive enhanced benefits that will help raise the quality of your care while reducing costs.

Durable Medical Equipment (DME) Certain medical equipment that is ordered by a doctor for use in the home. Examples are walkers, wheelchairs or hospital beds. DME is paid for under Medicare Part A and Part B for home health care services.

Excess Charges If you are in Original Medicare, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. The only time there are excess charges is when the provider does not accept Medicare.

Explanation of Benefits The statement sent to covered persons by their health plan listing services provided, amount billed and payment made.

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

Formulary A list of prescription drugs covered by a plan.

Generic Drug Prescription drugs that have the same active ingredients as brand-name drugs but cost less. Generic drugs are rated by the Food and Drug Administration (FDA) to be just as safe and effective as brand-name drugs.

Grievance A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered. (See Appeal.)

Health Insurance Portability and Accountability Act (HIPAA) A federal law, which requires all group health plans and health insurance issuers to provide evidence of a member's prior health coverage in the form of a certificate.

Health Maintenance Organization (HMO) A type of Medicare Advantage plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care services. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists or hospitals in the plan's network except in an emergency.

Home Health Care Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers), medical supplies and other services performed at or used at home.

Hospice Care A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver. Hospice care is covered under Medicare Part A. Hospice claims are paid by Medicare, not a Medicare Advantage plan.

Initial Enrollment Period When you become eligible for Medicare at 65, you have the three months before your birthday, your birthday month and the three months after (seven months total) to enroll in Medicare without financial penalty.

Inpatient Care Health care you receive when you are admitted to a hospital or skilled nursing facility.

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

Institution A facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF) or rehabilitation hospital. Private residences, such as an assisted living facility or group home, are not considered institutions for this purpose.

Lifetime Reserve Days In Original Medicare, a total of 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily copayment.

Long-Term Care A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

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.

Maximum Out-of-Pocket Limit A limit set by Medicare Advantage plans on the amount of money you will have to spend in a year. After you spend that amount, your Medicare-covered services are covered in full.

Medicaid A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered, if you qualify for both Medicare and Medicaid.

Medically Necessary Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage plans include HMOs, PPOs or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plan.

Medicare Advantage Prescription Drug Plan (MA-PD) A Medicare Advantage plan that offers Medicare prescription drug coverage (Part D) and Part A and Part B benefits in one plan.

Medicare-Approved Amount The total amount a doctor or hospital can be paid for a medical service.

Medicare Health Plan A plan offered by a private company that contracts with Medicare to provide you with your Medicare Part A and/or Part B benefits. Medicare health plans include Medicare Advantage plans (including HMO, PPO, Private Fee-for-Service plans, Medicare Cost plans, PACE plans or special needs plans). Other Medicare health plans include supplemental plans such as Medigap.

Medicare Managed Care Plan A type of Medicare Advantage plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists or hospitals in the plan's network. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs.

Medicare Prescription Drug Plan (PDP) A prescription drug plan run by Medicare-approved private insurance companies to help cover the cost of prescription drugs.

Medicare Savings Account Plan (MSA) A type of Medicare Advantage plan. These plans are similar to Health Savings Account (HSA) plans. With MSA plans, you can choose your health care services and providers. MSAs combine a high-deductible insurance plan with a medical savings account to pay for your health care costs. You're responsible for handling the money in your account, including deciding whether to pay for health care services using your account funds or other funds you have.

Medigap Open Enrollment Period A one-time-only, six-month period when you can buy any Medigap policy you want that is sold in your county. It starts in the first month that you are covered under Medicare Parts A and B. During this period, you cannot be denied enrollment or charged more due to past or present health problems.

Medigap Policy Medicare supplemental insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. Medigap policies only work with Original Medicare, not Medicare Advantage plans.

Network A group of health care providers (hospitals, doctors and pharmacies) that agree to participate with a Medicare Advantage plan.

Non-Formulary Drugs Prescription drugs not on a plan-approved drug list.

Original Medicare A fee-for-service health plan that lets you go to any doctor, hospital or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). If your provider does not accept Medicare, in some cases you may be charged more than the Medicare-approved amount. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).

Outpatient Hospital Care Medical or surgical care furnished by a hospital to you if you have not been admitted as an inpatient but are registered on hospital records as an outpatient. If a doctor orders that you must be placed under observation, it may be considered outpatient care, even if you stay under observation overnight.

Penalty An amount added to your monthly premium for Medicare Part B, or for a Medicare prescription drug plan, if you don't join when you're first able to. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-Service Option (POS) An HMO option that lets you use doctors and hospitals outside the plan network for an additional cost.

Pre-Existing Condition A health problem you had before the date that a new insurance policy starts.

Preferred Provider Organization (PPO) Plan A type of Medicare Advantage plan in which you pay less if you use doctors, hospitals and providers that belong to the network. You can use doctors, hospitals and providers outside of the network for an additional cost.

Premium The periodic payment to Medicare or an insurance company for health care and/or prescription drug coverage.

Preventive Services Health care screenings to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots and screening mammograms).

Primary Care Doctor A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care you need to keep you healthy. He or she may talk with other doctors and health care providers about your care and refer you to them. In many HMOs, you must see your primary care doctor before you can see any other health care provider.

Private Fee-for-Service (PFFS) Plan A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than Medicare, decides the terms, including how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits Original Medicare doesn't cover.

Programs of All-Inclusive Care for the Elderly (PACE) PACE combines medical, social and long-term care services for frail people to help them stay independent and living in their community as long as possible while getting the high-quality care they need. PACE is available only in states that have chosen to offer it under Medicaid.

Provider A person or organization (doctor, hospital, pharmacy, lab, outpatient clinic, etc.) that provides medical services.

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

Rehabilitation Rehabilitative services are ordered by your doctor to help you recover from an illness or injury. These services are given by nurses and physical, occupational and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Service Area The geographic area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may be required to disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Special Needs Plan A type of plan that provides more focused health care for people who meet a specific set of medical conditions, such as certain chronic medical conditions.

Specialist A doctor who treats only certain parts of the body, certain health problems or certain age groups. For example, some doctors treat only heart problems.

State Health Insurance Assistance Program (SHIP) A state program funded by the federal government that gives free local health insurance counseling to people with Medicare. Volunteer counselors provide information and assistance so that you can make your own decisions regarding which Medicare plan you choose.

State Medical Assistance Office A state agency that is in charge of the state's Medicaid program and can give information about programs that help pay medical bills for people with low incomes.

State Pharmacy Assistance Program A state program that provides people assistance in paying for drug coverage, based on financial need, age or medical condition and not based on current or former employment status. These programs are run and funded by the states.

Tiers To have lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form their tiers in different ways.

True Out-of-Pocket Costs (TrOOP) The amount paid toward the cost of your prescription drugs (deductible, copays, coinsurance and payments) during the course of the year.

TTY (711) A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing or have a severe speech impairment. A TTY consists of a keyboard, display screen and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages. Also known as Telecommunications Device for the Deaf (TDD). The national TTY relay number is 711.

Unassigned Claim A claim submitted for a service or supply by a provider who does not accept assignment.

Urgently Needed Care Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening.

Resources

For more information on Medicare:

Medicare Helpline

1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, available 24 hours a day, seven days a week.

www.medicare.gov

You can download a copy of the official Medicare handbook, "Medicare & You," or request that a copy be sent to you. There are also online tools to help you make your Medicare plan choices.

Social Security Administration

If you have questions about eligibility, enrollment or need extra help paying for Medicare, visit www.ssa.gov or call 1-800-772-1213, TTY: 1-800-325-0778, Monday – Friday, 7:00 a.m. – 7:00 p.m.

Erie County Department of Senior Services

Find out if you are eligible for financial assistance for your health care costs, as well as find information on other community programs for older adults. Call (716) 858-8526 (TTY: 711), Monday – Friday, 8:30 a.m. – 5:00 p.m. (July and August: 8:30 a.m. – 4:30 p.m.) or visit <http://www2.erie.gov/seniorservices/>.

New York State Health Insurance Program (NYSHIP)/Health Insurance Information Counseling and Assistance Program (HIICAP)

Find information about Medicare, Medicaid, managed care, EPIC and other health insurance options and issues. Call 1-800-701-0501 (TTY: 711), Monday – Friday, 8:30 a.m. – 4:30 p.m. or visit www.aging.ny.gov.

Railroad Retirement Board

If you worked for the railroad and want to find out more about your benefits, call 1-877-772-5772, TTY: 1-312-751-4701, Monday – Friday, 9:00 a.m. – 3:30 p.m. CST.

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

Find out if you are eligible for assistance in paying for your out-of-pocket Medicare Part D drug plan costs. Call EPIC at 1-800-332-3742 (TTY: 1-800-290-9138), Monday – Friday, 8:30 a.m. – 5:00 p.m.

Independent Health

Call us at (716) 635-4900 or 1-800-958-4405, TTY: 711 (October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m., April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.), visit us online at www.IndependentHealth.com/Medicare, email us at medicarehelp@IndependentHealth.com or speak with one of our RedShirtsSM at a Medicare Information Center near you. (A salesperson will be present with information and applications. For accommodations of persons with special needs at meetings, please contact us.)



Estimate Worksheet

Use this worksheet to help figure out your annual health care costs. By tracking your current expenses, you can estimate how much you can afford in the future. This will help when selecting the type of Medicare plan that is right for you.

Keep in mind this is just an estimate, and that your health care costs can vary widely from year to year. If you like, you can fill out worksheets for multiple years to get an even better view of how much you spend on health care.

NOTE: Your worksheets should be kept private and do not need to be shared with any health plans.



Medical needs:

Estimate the number of times you utilize each of the following services. Then, fill in the cost based on your current health plan (for example, a visit to your primary doctor may be a \$20 copayment). Multiply the times you use a service annually by the cost of that service to determine the total amount you spend on this service each year.

| Service | Number of Times Annually | Cost | Total |
|------------------------------------|--------------------------|------|-------|
| Example: Primary Doctor Visit | 3 | \$20 | \$60 |
| Premium (either annual or monthly) | | | |
| Primary Doctor Visit | | | |
| Specialist Visit | | | |
| X-Ray | | | |
| Laboratory Tests | | | |
| Inpatient Hospital Stay | | | |
| Outpatient Surgery | | | |
| Routine Annual Physical | | | |
| Colonoscopy | | | |
| Colorectal Screening | | | |
| Smoking Cessation | | | |
| Mammogram | | | |
| Pap Smear | | | |
| Bone Mass Measurement | | | |
| Prostate Screening | | | |
| Pneumonia Vaccine | | | |
| Hepatitis B Vaccine | | | |
| Flu Shot | | | |
| Grand total: | | | |

Pharmacy needs:



To determine your pharmacy needs, write in the quantity and the number of times you purchase each drug. Remember that some drugs can be bundled into a three-month (90-pill) supply. That means you only purchase this drug four times a year. Then, multiply the number of times you purchase per year by the cost per drug to calculate the total annual cost for each drug you use.

| Drug Name | Quantity of Medication (Ex. number of pills) | Number of Times Purchased Per Year | Cost Per Drug | Total |
|--------------------------------|--|------------------------------------|---------------|-------|
| Example: <i>Prescription A</i> | 30 | 12 | \$25 | \$300 |
| Example: <i>Prescription B</i> | 90 | 4 | \$10 | \$40 |
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| Grand total: | | | | |

Dental and vision needs:



Calculate your dental and vision needs in the same way as your medical needs.

| Service | Number of Times Annually | Cost | Total |
|--|--------------------------|------|-------|
| Example: Dental Exam/Cleaning | 1 | \$40 | \$40 |
| Dental Exams/Cleanings | | | |
| Dental X-Rays | | | |
| Eye Exams | | | |
| Contact Lenses or Prescription Eyeglasses (# of pairs) | | | |
| Grand total: | | | |

Other costs to consider:



Aside from health care needs like doctor visits and prescription drugs, there could be other expenses you have now that may be covered by certain Medicare Advantage plans.

| Service | Number of Times Annually | Cost | Total |
|--|--------------------------|-------|-------|
| Example: <i>Health Club Membership</i> | 1 | \$450 | \$450 |
| Example: <i>Acupuncture</i> | 6 | \$35 | \$210 |
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| | | | |
| Grand total: | | | |

Your annual health care expenses:



Now, it's time to determine how much you spend—and what you spend it on—every year.

1. Tally up the grand totals of each section, and write those four numbers in the grid below.

- These four numbers are important because each number indicates how much you spend on specific services—for example, if you spend a lot on prescription drugs, you may want to choose a plan that offers Part D.

2. Calculate the total of all four numbers.

- This final number is important because it indicates how much you spend annually on health care, which can help you better prepare for choosing a Medicare plan you can afford.

| Totals | |
|---|--|
| Grand Total for Medical Needs | |
| Grand Total for Pharmacy Needs | |
| Grand Total for Dental and Vision Needs | |
| Grand Total for Other Costs | |
| Your Total Health Care Expenses: | |

If you have any questions while filling out your worksheet, feel free to call us at (716) 635-4900 or 1-800-958-4405, TTY: 711 (October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.), visit us online at www.IndependentHealth.com/Medicare, email us at medicarehelp@IndependentHealth.com or speak with one of our RedShirtsSM at a Medicare Information Center near you. (A salesperson will be present with information and applications. For accommodations of persons with special needs at meetings, please contact us.)



We're always ready to help. Speak with a RedShirt® today.

Our experienced RedShirtsSM are ready to meet with you one-on-one at our conveniently located Medicare Information Centers.*

Here, we'll help you understand all of the Medicare Advantage plan options and make sure you choose the best plan. As Western New York's largest Medicare Advantage plan,** we do more to keep our members healthy. So you can enjoy retirement your way.

Visit a Medicare Information Center

For the most updated hours of operation and location information, visit: [IndependentHealth.com/FindARedShirt](https://www.independenthealth.com/FindARedShirt)

Hours: Monday – Friday, 9 a.m. – 4 p.m.

Cheektowaga/Depew

Valu Plaza
(across from Wegmans)
620 Dick Road
Depew, NY 14043

Jamestown/Lakewood

Independent Health
66 Chautauqua Avenue
Lakewood, NY 14750
Mon., Tues., Wed., 9 a.m. – 4 p.m.

Orchard Park

Tops Plaza
(near Tim Hortons)
3225 Southwestern Boulevard
Orchard Park, NY 14127

Tonawanda

Youngmann Plaza
(near Big Lots)
746 Young Street
Tonawanda, NY 14150
By appointment only

Williamsville

Independent Health
250 Essjay Road
Williamsville, NY 14221

*A salesperson will be present with information and applications. For accommodations of persons with special needs at meetings, please call (716) 635-4900 or 1-800-958-4405 (TTY: 711). **Per CMS WNY enrollment data 11/23.



www.IndependentHealth.com/Medicare