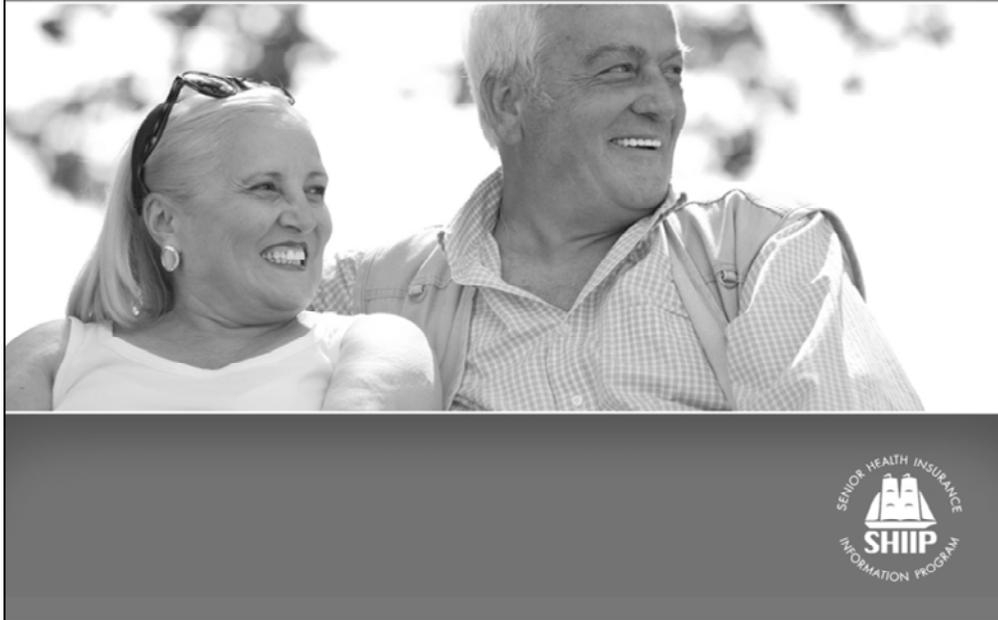


Welcome To Medicare



Greet and introduce yourself

What Is SHIIP?



Objective Information Source

- Part of the State of Iowa Insurance Division
- Answers questions and provides assistance
- Doesn't recommend or endorse specific companies, products or agents

- SHIIP is a service of the state of Iowa Insurance Division.
- We help Iowans on Medicare with questions and problems related to Medicare and health insurance. That includes Medicare Parts A & B, Medicare Advantage plans, Medicare Part D-drug coverage, Medicare supplement insurance and retiree health plans, long term care insurance, claims and medical assistance for people on Medicare.
- Our services are free, confidential and objective—we do not recommend or endorse any companies, policies or agents

Today We Will Cover



- Medicare eligibility, enrollment & costs
- Your Medicare choices:
 - Original Medicare Parts A & B
 - Supplementing Medicare
 - Prescription Drug Plans – Part D
 - Or
 - Medicare Advantage Plans – Part C

Today we will talk about who is eligible for Medicare, when you can enroll, when you should enroll, and the costs of Medicare enrollment.

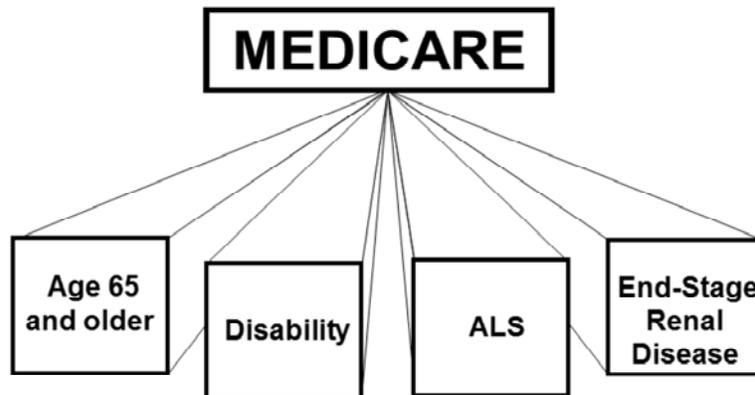
Then we'll discuss your choices for how to get your Medicare coverage.

- Original Medicare, which you may choose to supplement with other coverage such as retiree insurance or a Medicare Supplement plan, also known as a Medigap plan. You can then add Prescription Drug coverage
- OR
- You can choose a Medicare Advantage Plan (Part C) which includes your Part A Hospital and Part B Medical coverages and usually includes drug coverage as well.

MEDICARE - Who Is Eligible?



Must be a U.S. citizen or permanent resident for 5 years



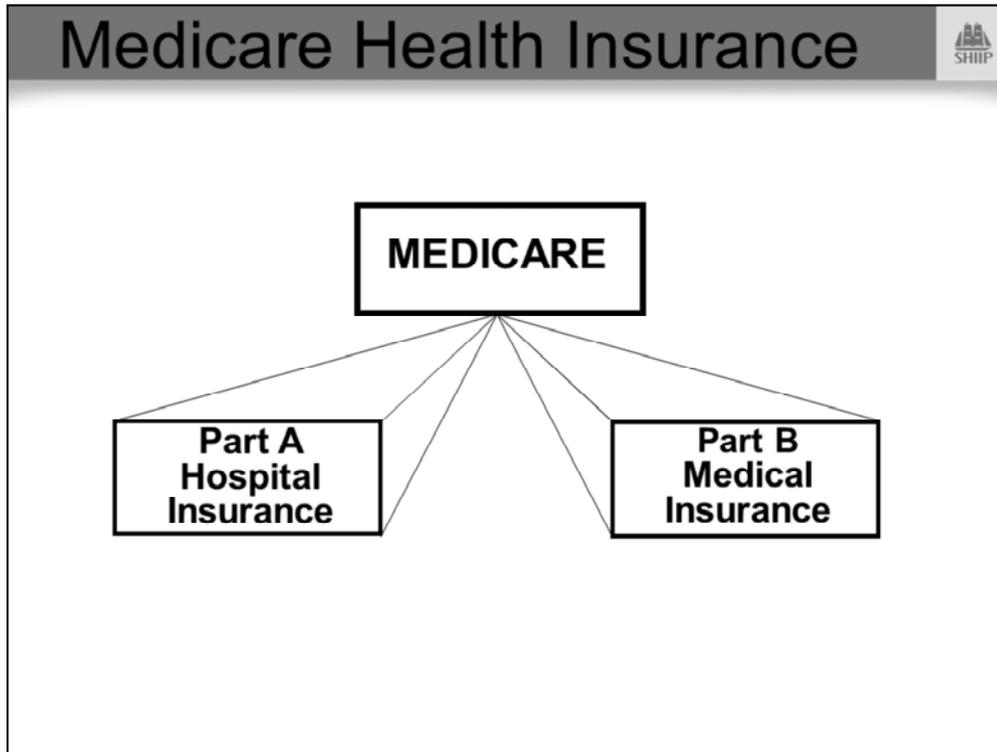
Medicare is health insurance for people:

- Age 65 and older
- Under age 65 with certain disabilities (who have been receiving Social Security disability benefits for a certain amount of time—24 months in most cases)
- People who have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig’s disease)
- People with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a transplant)

Medicare became effective July 1, 1966 and is the nation’s largest health insurance program, currently covering about 49 million Americans.

While Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA) is responsible for enrolling most people in Medicare. The Railroad Retirement Board (RRB) is responsible for enrolling railroad retirees.

Medicare Health Insurance



Medicare Part A is hospital insurance while Medicare Part B is medical insurance.

We'll discuss later what Parts A&B cover, but first let's talk about when to enroll and the costs of buying Part A&B

Should I enroll in Medicare?



If you are turning 65, you may be wondering whether you need to enroll in Medicare.

To answer that question, I need to ask for more information.

Are You Retired?



- Medicare is your primary coverage.
- Need to enroll in Medicare Part A and Part B.
- Retirement health coverage from employer will pay after Medicare.



Are both you and your spouse retired? That is, neither of you is actively working for an employer who provides you with health insurance.

- Medicare is your primary insurance regardless of any other health insurance you have.
- You should enroll in Medicare Part A and Part B.
- If you don't enroll at this time, you may pay a higher premium later.
- If you have retirement health insurance, it will pay after Medicare.

How To Enroll In Medicare When Retired



- Enrollment is automatic if you are drawing Social Security or Railroad Retirement benefits
- Otherwise
 - Call or visit SS or RR
 - Enroll online at www.socialsecurity.gov

A sample Medicare Health Insurance card for John D. Doe. The card is titled "MEDICARE HEALTH INSURANCE" and "SOCIAL SECURITY ACT". It lists the beneficiary's name as JOHN D. DOE, Medicare claim number as 123-45-6789A, and sex as MALE. It also indicates that the beneficiary is entitled to Hospital Insurance (Part A) starting 1/1/95 and Medical Insurance (Part B) starting 3/1/99. A signature line at the bottom is signed "John D. Doe".

MEDICARE HEALTH INSURANCE	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JOHN D. DOE	
MEDICARE CLAIM NUMBER SEX 123-45-6789A MALE	
IS ENTITLED TO EFFECTIVE DATE HOSPITAL INSURANCE (PART A) 1/1/95 MEDICAL INSURANCE (PART B) 3/1/99	
SIGN HERE	<i>John D. Doe</i>

If you are under 65 and getting Social Security or Railroad Retirement benefits at this time, you will automatically be enrolled in Medicare Part A and Part B and will get your card about 3 months before your 65th birthday.

If you are not getting Social Security benefits, you will need to apply for Medicare.

You can apply for Medicare by contacting Social Security. (Railroad Retirees contact the Railroad Retirement Board.) You can also apply for Medicare online at www.socialsecurity.gov.

SHIIP can help answer questions about on-line enrollment

Initial Enrollment Period



. You can sign up for Parts A& B anytime during a 7-month period that begins 3 months before the month you turn age 65 and ends 3 months after the month of your 65th birthday. This is called your Initial Enrollment Period.

Cost Of Enrolling In Medicare Part A



Part A is free for people who have 40 quarters of work credit under Social Security or Railroad Retirement.

- Part A is free for people who have 40 quarters of work credit under SS or RR.
- Enrolling in Part A (hospital coverage) is automatic if Part A is free for you and you are drawing Social Security benefits before you turn 65.
- If you are not drawing Social Security benefits before age 65, you can enroll in Part A anytime during your Initial Enrollment Period or afterwards.
- If Part A is free for you then there is no penalty for delaying enrollment in Part A after you turn 65.

Note to presenter:

Part A premium - 2017

30-39 quarters of Social Security work credit \$227

Less than 30 quarters of Social Security work credit \$413

Cost Of Enrolling In Medicare Part B



- People new to Medicare in 2017 pay \$134 per month for Part B.
- People with higher incomes pay more if their income is above:
 - \$85,000 individual
 - \$170,000 couple filing joint return

Part B premium in 2017:: When there is no Cost of Living Adjustment (COLA) in Social Security, the Part B premium does not increase for people who have their premium withheld from Social Security benefits. And, the law says your SS benefit will not be reduced by an increase in the Part B premium. In 2017 this means

- People who were already enrolled in Part B in 2015 AND who had their premiums deducted from Social Security will pay between \$104.90. and \$134.
- People who enrolled in Part B in 2016 and who had their premiums deducted from Social Security will pay between \$121.80 and \$134.
- People new to Part B in 2017 OR who do not draw Social Security benefits and therefore pay SS directly for their Part B premium will pay \$134 in 2017.

Before 2007 all Medicare beneficiaries paid the same monthly Part B premium representing 25% of the actual cost of the benefit. Beginning January 1, 2007, an individual or couple's modified annual adjusted gross income is used to determine how much is paid for the Part B premium.

Individuals who will pay more than the minimum premium in 2017 include: Individuals with an income greater than \$85,000(including those who are married and file separately) and couples who file a joint tax return with an income greater than \$170,000 (based on modified adjusted gross income from 2014 tax returns).

This is called IRMAA – which stands for “income related monthly adjusted amount”

IRMAA is withheld from your Social Security check. If you don't get a SS check, you will be billed for the IRMAA by Medicare.

The amount of premium these higher income people pay are found on page 1 of the Iowa Medicare Supplement & Premium Comparison Guide, which is in your packet.

Get Help Paying For Part B Premium

Medicare Savings Program – SLMB

- Income below:
 - \$1357 per month individual
 - \$1823 per month couple
- Resources below:
 - \$7280 individual
 - \$10930 couple

People whose income and resources are below these limits may have their Part B premium paid by the State of Iowa.

This is a Medicare Savings Program called Specified Low Income Medicare Beneficiary (SLMB)

Income is defined as gross income, before deductions

Resources include savings, investments, property you own if you do not live on that property. They do not include the home you live in or your car.

You apply for this assistance through the Department of Human Services (DHS) . SHIP counselors can help you with this application.

Note: Annual income limits: \$16,284 individual; \$21,876 couple

How Do I Pay The Part B Premium?



If you are drawing benefits, the premium is taken out of your monthly payment:

- Social Security
- Railroad Retirement
- Federal Government retirement

If you are not drawing benefits, you will be billed every 3 months

- If you choose to have Medicare Part B, the premium is automatically taken out of your monthly Social Security, Railroad Retirement or Federal Government retiree payment.
- For information about your Medicare Part B premiums, call Social Security or call the Office of Personnel Management if you are a retired Federal employee.
- If you do not get any of the above payments, Medicare sends you a bill for your Medicare Part B premium every 3 months. You may pay your bill by credit card, check, or money order. If you want to pay monthly, turn the billing over and follow the instructions. You will be able to set up automatic monthly withdrawal from your bank account. When you begin SS, the premium will come out of your monthly benefit check instead.

Employer has 20 or more* employees

- Can continue on employer plan
- Employer can't offer alternatives
- Employer coverage is primary
- Keep evidence of having insurance

*For those on Medicare due to disability,
the number of employees is 100 or more.

But what if you are not retired?

If you or your spouse continue to work , there are 20 or more employees where you work and you have employer health insurance:

You must be allowed to continue any health coverage you had before age 65. You don't need to enroll in Part A or Part B, but if you do, the employer insurance is still primary and Medicare is secondary.

If you are not signed up for Social Security or Railroad Retirement benefits you can delay Part A. If you're signed up for SSA or RR benefits, you will get Part A and you cannot refuse it. You can refuse Part B.

Enrolling in Part B isn't necessary until you or your spouse quit working or drop out of the employer health plan.

You won't pay a penalty at that time to enroll in Part B and there is never a penalty for delaying enrollment in Part A if it is free.

If you delay enrolling in Medicare because you are working and covered by employer health insurance, always keep evidence of that insurance coverage. You may need to show it later to prove you don't

need to pay a penalty for delaying enrollment in Part B.

Employer has fewer than 20 employees

- Employer can offer anything or nothing
- Medicare is primary insurance

When you turn 65, if you or your spouse continue to work and there are fewer than 20 employees:

- The employer is not required to give you the same health coverage as other employees. The employer can offer you another type of coverage or no coverage at all.
- Medicare will become your primary insurance, unless the employer and the employer's insurance company agree to remain primary.
- If the employer continues to provide health insurance you can delay enrolling in Part B and not face a late enrollment penalty later.
- It is important to contact your local Social Security office any time you fall into the situation of having employer coverage while you or your spouse work and you're turning 65. Verify with them your right to delay enrollment in Part B without penalty. Make note of the name of the person you spoke with, and the date and keep this information.

Should I Delay Enrolling In Part A While Working?



- Do you have a Health Savings Account?
- If so, do not enroll in Medicare while working
- Enrolling in Medicare means no longer eligible to make contributions to your HSA

One group of people who benefit from delaying enrollment in Part A are people whose employer plans are Qualified High Deductible Plans, and they have a Health Savings Account (HSA). IRS regulations state that someone with Medicare, even only Medicare Part A, is not eligible to make contributions to their Health Savings Account. (You can still make withdrawals from your HSA.)

If this is the kind of insurance you have, decide whether to keep your work insurance or enroll in Medicare. You should not have both.

When Part A is free, there is no penalty for delaying enrollment past age 65. You can enroll anytime. If you delay, when you do enroll, your Enrollment may be retroactive for up to 6 months, but not before age 65. This is important to know for tax purposes.

If Part A is free for you and you do not have a Health Savings Account and you are certain you will not have a Health Savings Account in the future while working, there is no harm in Enrolling in Part A during your Initial Enrollment Period.

Should I Delay Enrolling In Part B While Working?



- If you are actively working and covered by your employer's group health insurance, consider this:
- Part B coverage usually is secondary to employer coverage
- Part B costs a monthly premium
- Enrolling in Part B triggers a 6 month one-time guarantee to purchase a Medicare Supplement.

If you are actively working, why might you want to delay enrolling in Part B?

Part B coverage is usually secondary to employer coverage. It may pay little or nothing.

Part B costs a monthly premium - \$134 for many people in 2017.

Enrolling in Part B triggers a six month one-time guarantee to purchase a Medicare supplement without answering health questions. We will discuss this further when we talk about Medicare Supplement plans.

If you are retired, but are covered for health insurance by your spouse's current employer, and you are automatically enrolled in Medicare because you are drawing Social Security benefits, you can still delay enrollment in Part B. When you get your Medicare card, follow the instructions for returning the card and asking to delay enrollment in Part B.

If You Delay Enrolling In Medicare



Always verify a decision to delay enrollment with Social Security

Social Security makes the rules about enrolling in Medicare and Social Security interprets the rules. It is important to contact your local Social Security office any time you fall into the situation of having employer coverage while you or your spouse work and you're turning 65. Verify with them you right to delay enrollment in Part B without penalty. Make note of the name of the person you spoke with, and the date, and keep this information.

When You Retire



Enroll in Part A if not enrolled previously

Enroll in Part B

- You have up to 8 months after worker retires to enroll in Part B

•If you didn't take Part B when you were first eligible because you or your spouse were working and you had group health coverage through your or your spouse's employer or union, you can sign up for Part B during a Special Enrollment Period. People who sign up for Part B during a Special Enrollment Period do not pay higher premiums. You can sign up:

Any time you are still covered by the employer or union group health plan through your or your spouse's current or active employment OR

During the 8 months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

Call SSA or the Railroad Retirement Board if you have questions about the date to enroll or the amount of your premiums.



If you are already enrolled in Part A and want to enroll in Part B, you need two forms.

- CMS-40B Application for Enrollment in Part B
- CMS L564 Request for Employment Information

These forms are available by visiting a Social Security office, calling a Social Security office to request they be mailed to you, or you can print them from Medicare’s website.

Medicare’s website is www.Medicare.gov.

From the home page, click on “Forms, Help and Resources” in the upper right corner. On the drop-down box, look for “Forms”. This will take you to where you can print the two forms you need, CMS-40B Application for Enrolling in Part B and CMS-L564, Request for Employment Information (You don’t need to know the form numbers, just look for where you select that you want to add Part B while employed)

Return the completed forms to your local Social Security office. You can find the address of your local Social Security office on www.socialsecurity.gov. Or, a SHIP counselor can give you this information. If you mail these forms, send them certified, signature required, and be sure to allow adequate time for the Social Security office to receive them before your requested effective date.

What If You Don't Enroll In Part B



During Your IEP Or When You Retire?

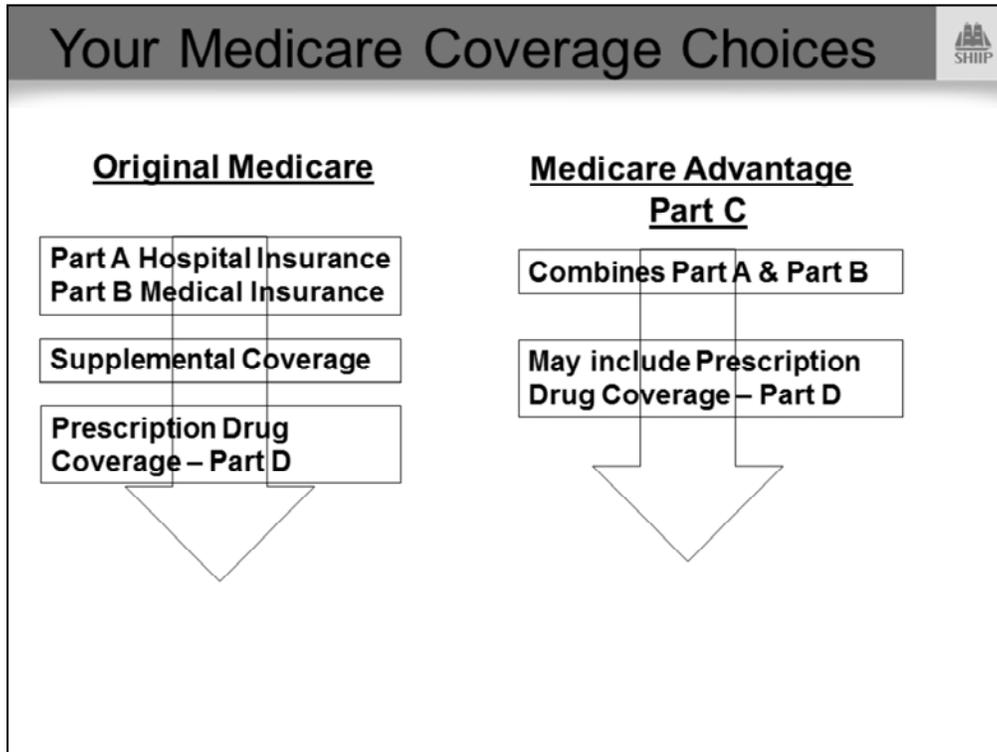
General Enrollment Period

- January 1 through March 31 each year
- Coverage effective July 1
- Premium increases 10% for each 12-month period you were eligible but did not enroll
- Pay this penalty as long as you have Part B

•If you did not choose Part B when you were first eligible at age 65, or during a Special Enrollment Period triggered by stopping work, you may sign up during a General Enrollment Period. This period runs from January 1 through March 31 of each year, with coverage effective July 1 of that year.

•However, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases. In most cases, you will have to pay this penalty for as long as you have Part B.

•Can buy into Part B, even if you don't have 10 years of paying into Part A, by paying a monthly premium.



- You have two choices for how to receive your Medicare benefits
- Option 1—Original or traditional Medicare. The government pays a share for your Part A and Part B benefits and you have the option of getting supplemental insurance to cover some or all of the costs of Part A and B benefits which Medicare does not pay. You can also enroll in a Part D drug plan for drug coverage. .
- Option 2—Some years ago Congress decided that beneficiaries should have more than one way to receive their Medicare benefits. They created Medicare health plans, now called Medicare Advantage plans. Medicare Advantage plans are offered by private insurance companies and provide your Part A and Part B benefits. Some also include Part D drug coverage.
- We will start with the Original Medicare option and then discuss the Medicare Advantage option

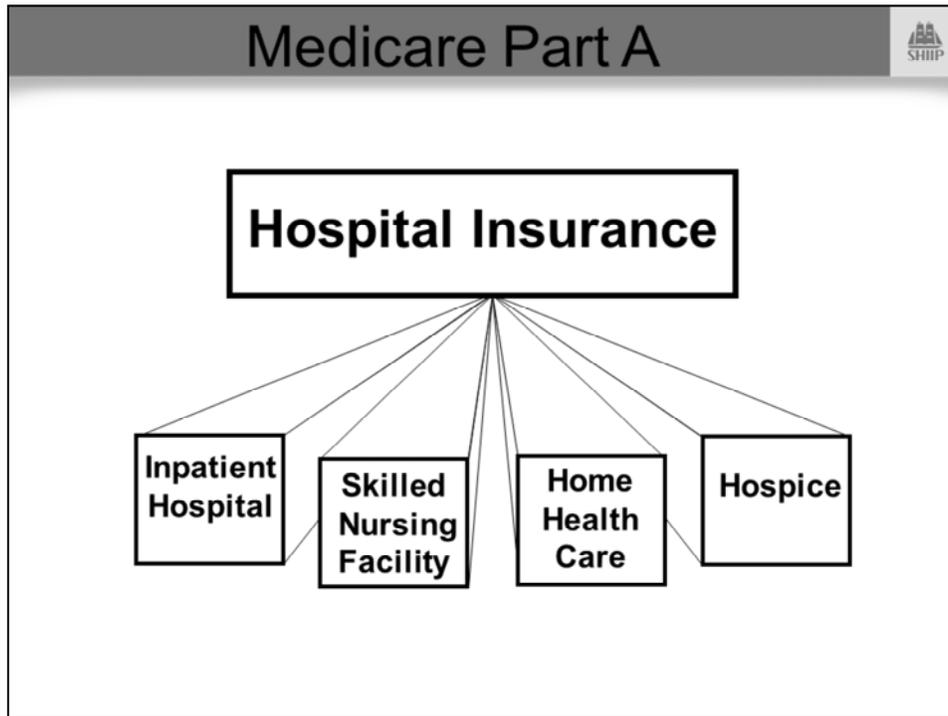
Original Medicare



You are not limited to a provider network. With original Medicare Parts A and B you can use any provider anywhere in the US who accepts Medicare and has a provider number.



- One thing to know about original Medicare is that you can see any provider who accepts Medicare and has a Medicare provider number.
- There is no provider network and you also are not required to have a referral before seeing a specialist.



REFER TO: Page 1 of Iowa Medicare Supplement & Premium Comparison Guide

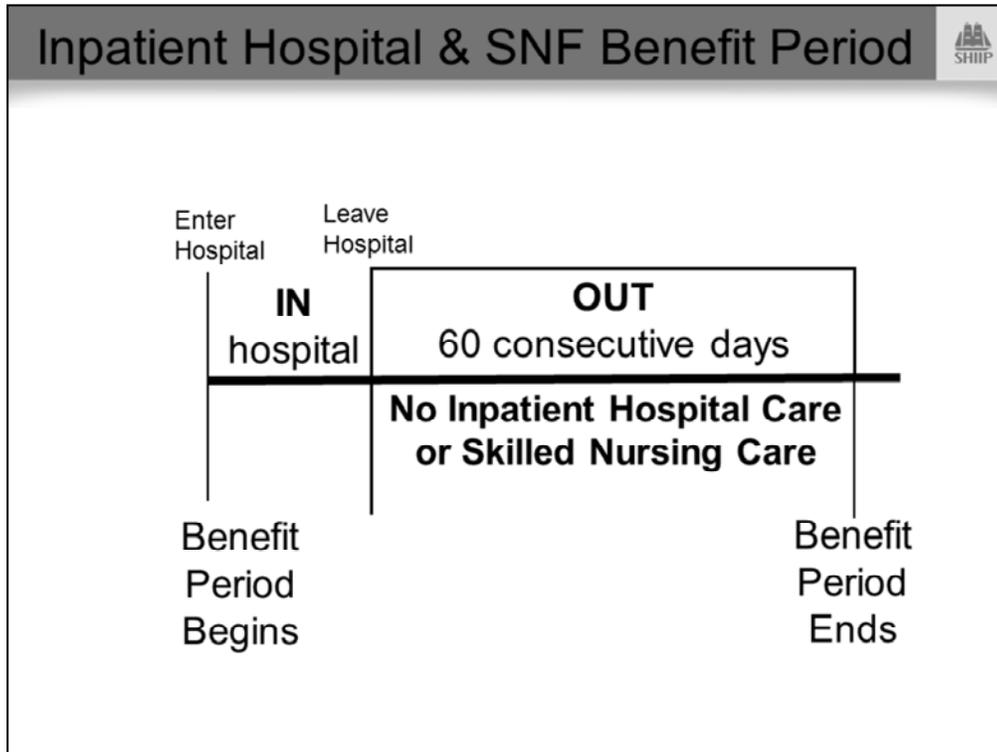
Medicare Part A, hospital coverage, helps pay for

- Hospital inpatient care

- Skilled nursing facility (SNF) care (not custodial or long-term care)

- Some home health care

- Hospice care



Let's look at what you will pay for hospital stays.

- First, we need to understand what a benefit period is.

A benefit period refers to the way Medicare measures your use of hospital and skilled nursing facility (SNF) services.

A benefit period begins the day you are admitted to a hospital as an inpatient.

The benefit period ends when you have not received Medicare-reimbursed hospital or skilled nursing care for 60 days in a row.

If you go into the hospital after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible (\$1,316 in 2017) for each benefit period.

- There is no limit to the number of benefit periods you can have.

Part A Inpatient - What You Pay



Days 1-60	Days 61-90	60 Lifetime Reserve Days	You pay all costs
Deductible \$1,316	Daily Coinsurance \$329	Daily Coinsurance \$658	
Renewable days	Renewable days	Each day available only once	

REFER TO: Page 2 of Iowa Medicare Supplement & Premium Comparison Guide

In the Original Medicare Plan, for each benefit period in 2017 you pay:

- A total of \$1,316 for a hospital stay of 1 – 60 days
- \$329 per day for days 61 – 90 of a hospital stay
- \$658 per day for days 91 – 150 of a hospital stay. These days are covered under your Lifetime Reserve Days. Lifetime Reserve Days are 60 days that Medicare will pay for when you are in a hospital for more than 90 days in a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for the daily coinsurance amount.
- All costs for each day beyond 150 days

Skilled Nursing Facility Care - What You Pay



Requirements:

- 3-day inpatient hospital stay
- Need daily skilled care
- Use a Medicare-certified skilled nursing facility (SNF)

Days 1-20	Days 21-100	You pay all costs
Medicare pays 100%	Daily Coinsurance \$164.50	

Medicare Part A will pay for skilled nursing facility (SNF) care for people with Medicare who **meet all** of the following conditions:

- Your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a skilled nursing facility; and
 - You have been admitted as an inpatient in a hospital at least 3 consecutive days or more, not counting the day you leave the hospital, before you are admitted to a participating SNF; and
 - You are admitted to the SNF within 30 days after you leave the hospital; and
 - Your care in the SNF is for a condition that was treated in the hospital; and the facility **MUST** be a Medicare participating SNF.
- Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay.
 - Under the Original Medicare Plan, for days 21 – 100, SNF care is covered except for coinsurance of up to \$164.50 per day in 2017.
 - After 100 days, Medicare Part A no longer covers SNF care. Keep in mind that skilled nursing care is different from nursing home care. Most nursing home care is custodial (or non-skilled) care, such as help with dressing, bathing, eating or other activities of daily living, which is not covered by Medicare.

Home Health Care – What You Pay



Covered Services – no cost

- Part-time skilled nursing care
- Therapy—occupational, physical, speech-language
- Some home health aid services

- Home health care includes part-time or intermittent skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services such as help with personal care (bathing, using the toilet, or dressing), and medical social services.
- Medicare Part A pays for your home health services for as long as you are eligible and your doctor says you need these services. (Part B also may pay for home health care under certain conditions.)
- However, there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services. **Home Health Care is NOT long-term care!**
- To be eligible, you must meet four conditions:
 1. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
 2. You must need at least one of the following services: intermittent (not full time) skilled nursing care, physical therapy, speech language pathology services, or continue to need occupational therapy.
 3. You must be homebound, which means that you are normally unable to leave home or that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care (may include adult day care) or attend a religious service.
 4. The home health agency caring for you must be approved by Medicare.

Hospice Services –What You Pay



- You pay nothing for hospice care from a Medicare-certified Hospice provider.
- You may pay part of the cost of medications and respite care

•Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families.

•You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than 6 months to live

•Hospice care is usually given in your home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed; Medicare must also approve the hospice care provider.

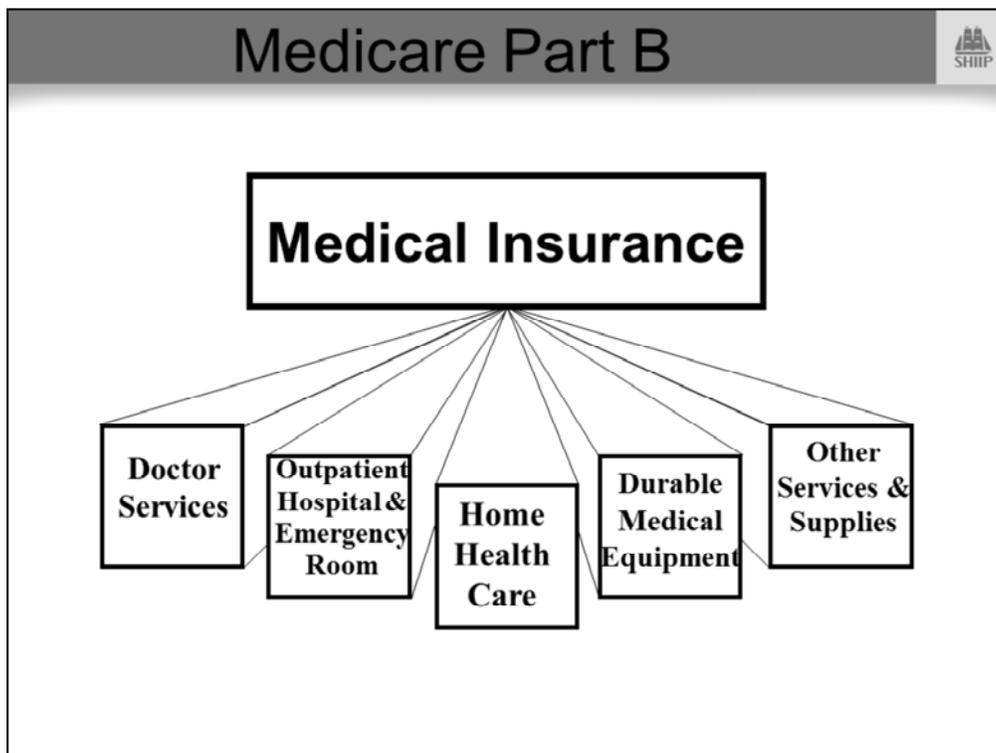
•You must sign a statement choosing hospice care instead of routine Medicare covered benefits to treat your terminal illness. However, medical services not related to the hospice condition would still be covered by Medicare.

•Services covered include: medical equipment and supplies, drugs for symptom control and pain relief (other prescriptions would be covered under Part D), respite care, home health aide and homemaker services, social worker services, dietary counseling, grief counseling.

you pay a copayment of no more than \$5 for each prescription drug and other similar products for pain relief and symptom control and

5% of the Medicare-approved payment amount for inpatient respite care.

Room and board are generally not payable by Medicare except in certain cases.



REFER TO: Page 1 of Iowa Medicare Supplement & Premium Comparison Guide

Doctors' services - wherever doctor provides care

Outpatient, Emergency

Can be outpatient even if kept over night. Ask what your status is.

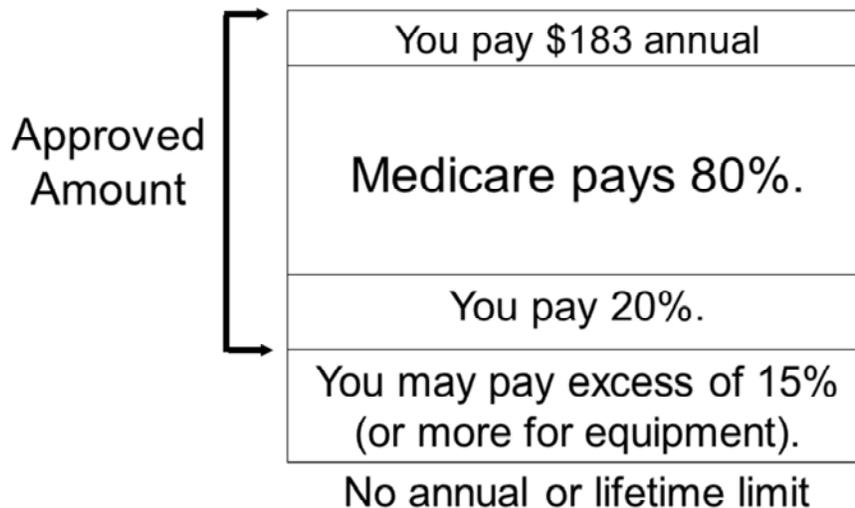
Home Health - some under Part A and some under

Part B- but if you have only A or B, all types of eligible home health services are paid.

Durable Medical Equipment such as walkers, wheel chairs, oxygen equipment, and diabetic supplies.

Other Services & Supplies such as ambulances, laboratories, therapy

Medicare Part B - Payments For Services



•**REFER TO:** Page 2 of Iowa Medicare Supplement & Premium Comparison Guide

- If you are in the Original Medicare Plan, you pay the Medicare Part B deductible which is the amount a person with Medicare must pay for health care each calendar year before Medicare begins to pay.
- This amount can change every year in January. For 2017 the amount is \$183. This means that you must pay the first \$183 of your Medicare-approved medical bills in 2017 before Medicare Part B starts to pay for your care.
- You also pay some co-payments or coinsurance for Part B services. The amount depends upon the service, but is 20% of the amount Medicare approves in most cases.
- We will discuss “excess charges” on the next slide.

Medicare Part B - Claims



If provider accepts “assignment”

- Agree to accept Medicare’s “approved” amount as full payment
- You only pay deductibles & coinsurance
- Medicare sends its payment directly to the provider

If provider does not accept “assignment”

- May charge up to 15% more than the “approved” amount
- May ask you to pay entire charge at time of service
- Medicare sends its payment to you and you pay the provider

To understand the Original Medicare Plan, it is important to define the term “assignment.” Assignment is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare. Doctors or providers who accept assignment from Medicare agree to be paid by Medicare and agree to get only the amount Medicare approves for their services. Providers who accept assignment can only charge people with Medicare the Medicare deductible and/or coinsurance amount.

If a doctor, other health care supplier, or provider doesn’t agree to accept assignment, they may charge you more than the Medicare-approved amount. For most services, there is a limit how much over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other providers who don’t accept assignment is called the limiting charge. The limiting charge is 15% over the Medicare-approved amount. The limiting charge doesn’t apply to supplies and durable medical equipment. **In addition, you may have to pay the entire charge at the time of service.** Medicare will send you its share of the charge when the claim is processed.

Covered Preventive Services



- Welcome to Medicare preventive visit
- Annual wellness visit
- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Cardiovascular screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screening
- Flu shots, pneumococcal shots & Hepatitis B shots
- Glaucoma tests
- Hepatitis C screening
- Lung cancer screening
- Mammograms (screening)
- Obesity screening & counseling
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Smoking cessation

REFER TO: *Medicare Preventive Benefits* factsheet.

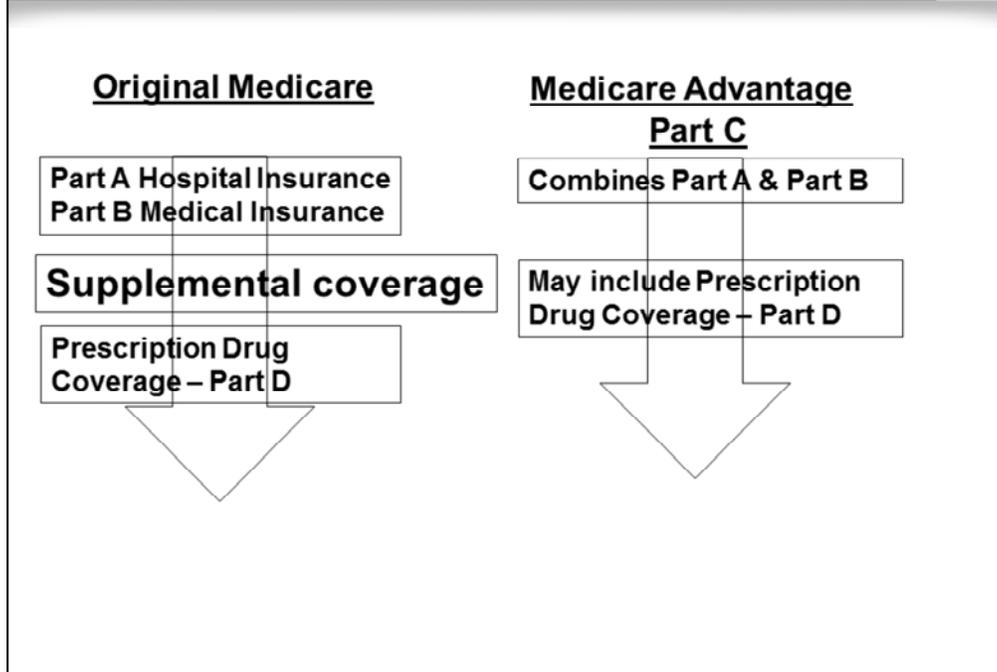
Medicare Part B also covers preventive services like exams, lab tests, and screening shots to help prevent, find, or manage a medical problem. It's important to take advantage of these important benefits. Note when you are eligible for the benefits and how often you can receive the various services.

Newly added preventive benefits include a second pneumococcal pneumonia vaccine a year after administration of the first vaccine, lung cancer screening for people with a history of smoking, screening for the Hepatitis C virus for people born between 1945 and 1965, or who meet other conditions, and an added colorectal cancer screening.

Starting January 1, 2011 the only preventive services which will have cost sharing are glaucoma screening, prostate cancer screening, colorectal cancer screening (for people who are not high risk) and diabetes self-management training services. The other preventive services have no cost sharing if the provider accepts

Medicare assignment.

Supplemental Insurance Choices



When you choose to go the original Medicare route, the second decision you have to make is what supplemental insurance you want.

Options For Filling Medicare's Gaps



- Medicare Supplement insurance
- Retiree health plan from employer
- Medicare Savings Program – QMB
- Medicaid
- TRICARE/TRICARE for Life
- Indian Health Services/tribal medical benefits

Original Medicare Plan pays for many health care services and supplies, but it doesn't pay all of your health care costs.

There are costs you must pay, like coinsurance, copayments and deductibles. These costs are sometimes called "gaps" in Medicare coverage.

Many people have coverage in addition to Part A & B to supplement what Medicare pays.

Supplemental health and drug coverage may be available through sources such as:

- A Medicare Supplement or Medigap policy
- Retiree health plan from former employer
- Medicare Savings Program or Medicaid
- TRICARE or TRICARE for life for military retirees
- Indian Health Services/tribal medical benefits

Medicare Supplement Insurance



- Health insurance policies sold by private insurance companies
- Also called “Medigap”
- Cover “gaps” in Original Medicare Plan
- 10 standardized policies
 - Plans A, B, C, D, F, G, K, L, M, N
- Guaranteed renewable

REFER TO: *Iowa Medicare Supplement & Premium Comparison Guide*

- A Medigap or Medicare Supplement policy is a health insurance policy sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. The companies must follow Federal and state laws that protect people with Medicare.
- The standardized Medicare Supplement policies must provide the same benefits, but the costs may differ among companies. They are identified by the letters, A, B, C, D, F, G, K, L, M & N
- When you buy a Medicare Supplement policy, you pay a **premium** to the Medicare Supplement insurance company. As long as you pay your premium, your policy will be automatically renewed each year. This is called guaranteed renewable.
- This premium is in addition to your monthly Medicare Part B premium.

How Much Does A Medicare Supplement Cost?



Insurance Company	Age	Standardized Medicare Supplement Plans Available - Annual Premiums											Notes *	Comments **	
		A	B	C	D	F	F (HD)	G	K	L	M	N			
AARP/UnitedHealthcare Insurance Co. 1-800-523-5800 www.aarphealthcare.com (Rates for smokers differ)	65	\$896	\$1,280	\$1,576		\$1,585			\$547	\$858			\$1,127	C	
	70	\$1,093	\$1,560	\$1,919		\$1,929			\$670	\$1,047			\$1,373	NA	Pre-X: 3 Months
	75	\$1,421	\$2,025	\$2,491		\$2,504			\$874	\$1,362			\$1,784	S	
	80	\$1,421	\$2,025	\$2,491		\$2,504			\$874	\$1,362			\$1,784	S0	GI: None Sales***: G
American Republic Corp Insurance Co. 1-888-755-3065 www.americanenterprise.com (Smoker rates differ; Rates for females are lower)	65	\$1,511				\$2,046	\$702		\$948	\$1,306				C	
	70	\$1,694				\$2,293	\$787		\$1,063	\$1,464				AA	Pre-X: None
	75	\$2,052				\$2,779	\$954		\$1,288	\$1,773				Z	GI: None
	80	\$2,264				\$3,201	\$1,099		\$1,484	\$2,043				S0	GI: None Sales***: L, A
American Republic Insurance Co. 1-888-755-3065 www.americanenterprise.com (Smoker rates differ; Rates for females are lower)	65	\$1,133				\$1,619	\$648							C	
	70	\$1,197				\$1,710	\$684							AA	Pre-X: None
	75	\$1,493				\$2,132	\$853							Z	GI: None
	80	\$1,777				\$2,539	\$1,016							S0	GI: None Sales***: L, A
American Retirement Life Insurance Co. 1-866-459-4272 (no website) (Rates for females are lower)	65	\$1,463				\$1,803	\$1,551						\$1,235	C	
	70	\$1,719				\$2,104	\$1,841						\$1,458	AA	Pre-X: 6 Months
	75	\$1,978				\$2,451	\$2,174						\$1,726	Z	
	80	\$2,223				\$2,841	\$2,539						\$2,031	S20	GI: None Sales***: L, A
Assured Life Association 1-877-223-3666 www.denverwoodmen.org (Smoker rates differ; Rates for females lower)	65	\$1,357	\$1,556	\$1,923	\$1,587	\$2,024	\$1,593						\$1,108	C	
	70	\$1,605	\$1,838	\$2,280	\$1,881	\$2,399	\$1,888						\$1,314	AA	Pre-X: None
	75	\$1,780	\$2,063	\$2,573	\$2,126	\$2,707	\$2,134						\$1,489	Z	GI: None
	80	\$1,892	\$2,226	\$2,794	\$2,315	\$2,940	\$2,324						\$1,627	S25	GI: None Sales***: L, A

*Notes: C=Automatic Crossover Claims Filing; IA=Issue Age Premium Basis; AA=Attained Age Premium Basis; NA=Premium Not Based on Age
S=Statewide Premium; Z=Premiums for Des Moines Zip Code Area; S=One Time Policy Fee

**Comments: Pre-X=Pre-existing Condition(s) Waiting Period; GI=Guaranteed Issue Plans Available

***Sales: I=Policies sold on an individual basis; G=Policies sold on a group basis
A=Policies sold by an agent; M=Policies sold directly from the company through a website or mail

Page 26

Refer to page 26 of *Iowa Medicare Supplement & Premium Comparison Guide*

Starting on page 26 for those age 65 and older, or on page 38 for those on Medicare due to disability, you will find a listing of companies who write Medicare Supplement policies in Iowa. This is not every company that writes these policies; companies are not required to allow SHIIP to publish their premiums, and there are a handful who have chosen not to be included.

The premiums shown are annual premiums at certain ages. In the “notes” column on the right side of the page, second line, you will see “AA” or “IA”. AA means attained age. The premiums on these policies increase as you get older. IA means issue age; the premium on these policies will not increase because you age. However, the premiums on both types can change when Medical costs change and the insurance companies request that the Iowa Insurance Division approve new premiums.

Some companies have different premiums for males and females. Where this is the case, we show the costs for a male. Some companies charge the same premium state-wide while others vary their premium by zip code. Our guide includes premiums for zip 503, which is Des Moines.

These premiums are a guide, not an exact quote. Some companies offer discounts we don’t show here such as a “household” discount. To find out the exact cost for you, contact the company or an agent. Contact information is shown under the

company name in the left hand column.

Standard Plans -- 10 Benefit Packages



Ten Standard Medicare Supplement Plans										
Basic Benefits	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Part A Hospital										
Day 61-90 Coinsurance	X	X	X	X	X	X	X	X	X	X
Day 91-150 Coinsurance	X	X	X	X	X	X	X	X	X	X
365 more days – 100%	X	X	X	X	X	X	X	X	X	X
Part A Hospice coinsurance	X	X	X	X	X	X	50%	75%	X	X
Part B Coinsurance or Copay	X	X	X	X	X	X	50%**	75%**	X	X****
Parts A & B Blood	X	X	X	X	X	X	50%	75%	X	X
Additional Benefits	A	B	C	D	F	G	K	L	M	N
Skilled Nursing Facility										
Coinsurance Day 21-100			X	X	X	X	50%	75%	X	X
Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Part B Deductible			X		X					
Part B Excess					X	X				
Foreign Travel Emergency			X	X	X	X			X	X
Out-of-pocket annual limit							\$4,960 ***	\$2,480 ***		

Refer to page 3 of *Iowa Medicare Supplement & Premium Comparison Guide*

In this chart, an X in the box means that the Plan shown at the top of the column covers the out-of-pocket expense shown on the left. So you can see on the top line that all the plans cover the daily coinsurance that Medicare Part A does not cover from days 61-90 in a hospital. A few lines farther down, you see that all the plans cover the Part B coinsurance although Plans K & L only cover part of the coinsurance, and Plan N has a copay of up to \$20 at a doctor's office and \$50 at an emergency room.

The plans start getting different from each other below the "Additional Benefits" line. For example, only Plans C and F cover the annual Part B deductible. Only Plans F and G cover Part B excess (when the provider does not accept assignment). Several of the plans provide some limited foreign travel emergency coverage.

Plan F has the most coverage; it is the Cadillac. It also has the highest premiums. Other plans may leave you with more out-of-pocket costs when you use care, but a lower premium. There is also a high deductible Plan F, in which you are responsible in 2016 for the first \$2180 that Medicare does not cover. After that, Plan F benefits apply. This is the least expensive supplement plan.

Guaranteed Access - Open Enrollment



- Available at age 65 or older
- Triggered when Medicare Part B starts
- Lasts six months from Part B effective date
- Can't be turned down
- Pay "preferred" premium

MONTH YOU QUALIFY



FIVE MONTHS AFTER



Open Enrollment Period

REFER TO: Page 5 of *Iowa Medicare Supplement & Premium Comparison Guide*

Most Medicare coverages are available regardless of your health. The question is “when” can you enroll, not “whether” you can enroll. Medicare Supplement plans are the exception.

When you first go on Medicare Part B at age 65 or older you get a Medicare supplement “open enrollment”. The first six months you are on Medicare Part B you can enroll in any Medicare supplement that is offered in Iowa and the company cannot reject you for any existing health conditions and it cannot charge you more than anyone else your age. There is no annual open enrollment for Medicare Supplement plans. After the six month period ends, companies can use medical underwriting (review your health history) to determine if they will cover you and to determine your premium.

There is no open enrollment for those under age 65.

Outside of this six month open enrollment period, there are limited circumstances in which you can buy a Medicare Supplement without answering health questions. Those are described on page 6 and 7 in the Medicare Supplement & Premium Comparison Guide.

How To Avoid A Waiting Period For Coverage Of Pre-existing Conditions



- During the first 6 months of being enrolled in Part B
IF you apply within 63 days of loss of creditable
coverage
 - OR
- If the new Medicare Supplement policy replaces
your current Medicare Supplement policy
 - OR
- If a company has no waiting period

REFER TO: Page 5 of *Iowa Medicare Supplement & Premium Comparison Guide*

Although the insurance company is required to sell you a Medicare Supplement plan regardless of your health during your six month open enrollment period, it can have a waiting period before it covers pre-existing health conditions. The maximum waiting period is 6 months.

You can avoid a waiting period if:

- During your 6 month open enrollment period, you apply for your Medicare supplement within 63 days of when you lose creditable coverage—previous health insurance.
- You apply for a Medicare supplement policy to replace one you have had for at least six months, and no gap occurs between the end of the old policy and the beginning of the new policy.

Some companies do not have a waiting period (Point out “Notes” in the premium comparison portion of the Guide.)

Employer Retiree Health Plans



- How does your plan coordinate with Medicare?
- What is the premium?
- Are there any extra benefits?
- Does it have prescription drug coverage as good as or better than Medicare's?
- Is there a provider network?

- If you have a retiree plan, you need to understand what it covers and how it coordinates with Medicare. Retiree plans may be better, worse or somewhere in-between when compared to regular Medicare Supplement plans.
- Many employer-provided plans have coordination of benefits and may or may not pay everything Medicare does not cover.
- What is the premium?
- Some plans may include vision and hearing services and dental care, not covered under original Medicare or a Medicare Supplement plan.
- The retiree plan may include prescription drug coverage that is better than a Medicare prescription drug plan.
- Some retiree plans are group Medicare Advantage plans which have provider networks that must be used.
- It is important to understand your retiree coverage. With most retiree plans, if you leave the plan, you cannot return.

Medicare Savings Programs



Qualified Medicare Beneficiary (QMB)

- Pays Medicare premium(s), deductibles & coinsurance
- Income Limits:
 - \$1010 per month – individual
 - \$1355 per month – couple
- Resource Limits:
 - \$7280 – individual
 - \$10,930 – couple

•The Iowa Dept. of Human Services also has programs that pay Medicare premiums, and in some cases may also pay Medicare deductibles and coinsurance, for people with limited income and resources.

•These programs are called Medicare Savings Programs. One such program, discussed previously, is SLMB which pays the Part B premium. Another Medicare Savings Program is the Qualified Medicare Beneficiary (QMB). QMB pays Medicare premiums, deductibles and coinsurance. .

•Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.

Note: Annual income – 12,120 individual; \$16,260 couple

Prescription Drug Coverage Choices



Original Medicare

Part A Hospital Insurance
Part B Medical Insurance

Supplemental coverage

Prescription Drug
Coverage – Part D

Medicare Advantage Part C

Combines Part A & Part B

May include Prescription
Drug Coverage – Part D



Now we'll discuss Medicare Part D or the Prescription Drug Benefit.

Medicare Part D



- Available for all people with Medicare
 - Enrolled in Part A and/or Part B
 - Includes those on Medicare due to disability, ALS or ESRD



- As of January 1, 2006, everyone with Medicare became eligible to join a Medicare prescription drug plan to help lower prescription drug costs. CMS contracts with private companies offering prescription drug plans to negotiate discounted prices on behalf of their enrollees.
- Anyone who has Medicare Part A (hospital coverage) and/or Part B (medical coverage) is eligible to join a Medicare prescription drug plan, including those on Medicare due to disability, ALS or ESRD. No health questions are asked. Your plan must be one available where you live, i.e., Iowa.
- Enrolling in a Medicare Prescription Drug plan is not mandatory.
- However, there are only certain times that you can enroll in a plan, and if you do not enroll when you are first eligible, but later decide you want coverage, you may have to wait to enroll.
- If you do not have “creditable” drug coverage once you have enrolled in either Medicare A or B, when you enroll in a drug plan later, you will be subject to a Late Enrollment Penalty.

What Is “Creditable Coverage” ?



- Drug coverage that is as good as or better than a Medicare prescription drug plan
- Includes:
 - VA drug benefits
 - Tricare for Life
 - Some employer or retiree coverage
 - Indian Health Services

What does “creditable coverage” mean? It is drug coverage that is as good as, or better than, a Medicare prescription drug plan.

Veterans drug benefits, Tricare for Life, Indian Health Services and some employer or retiree plans are creditable.

Your employer’s Human Resource department or insurer will know whether the drug coverage they offer you is creditable.

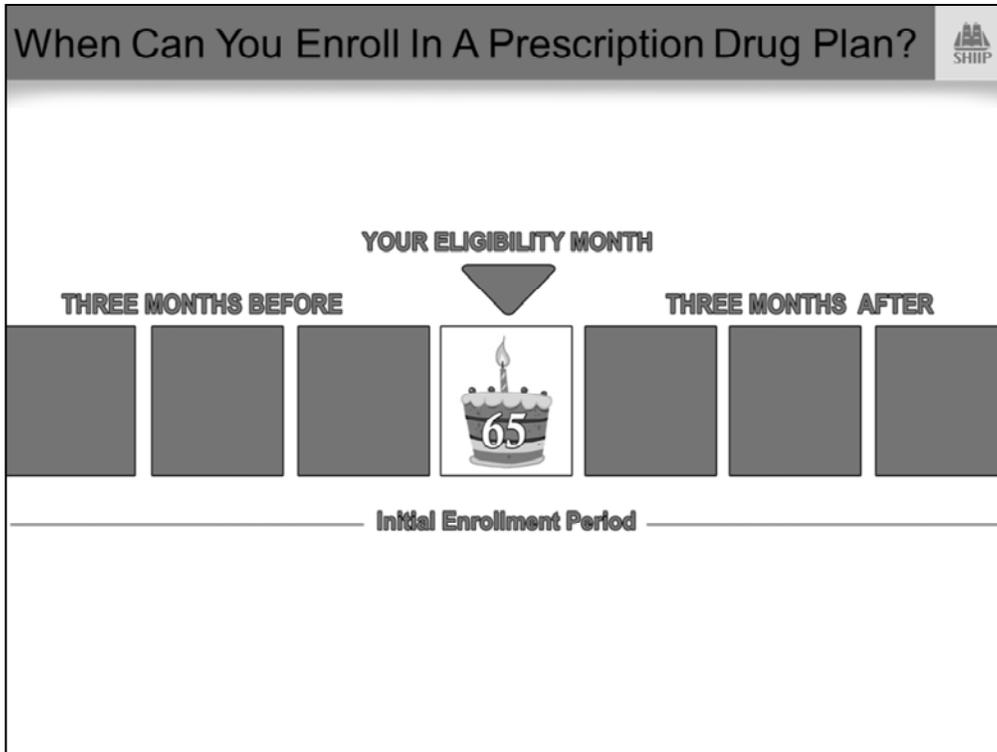
What Is The Late Enrollment Penalty?



- Assessed 1% of base premium* for every month you were eligible to enroll in Medicare's prescription drug coverage and did not enroll
- Pay penalty for life
- Example: Did not enroll in 2006-your penalty would be 127 months X 1% or 127% X \$35.63 or \$45,26 per month in penalty
- * \$35.63 in 2017

- If you don't have continuous creditable drug coverage while enrolled in Medicare A or B, then when you do enroll, you will have a late enrollment penalty.
- This penalty is a premium that is 1% higher for each month you waited to join and did not have coverage at least as good as Medicare prescription drug coverage. You will have to pay this penalty as long as you have Medicare prescription drug coverage.
- Example: Person who did not enroll during Part D initial enrollment period in 2006 (but was eligible then) but then enrolled to start Part D January 1, 2017 would have a 127 month penalty—June-December in 2006 and the 12 months of 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015 and 2016.

Note: 127 months consists of the last 7 months of 2006 and 12 months each of the next 10 years (2007-2016).



- A new Medicare Beneficiary can join a drug plan any time during their Initial Enrollment Period, the 7 month period surrounding an individual's eligibility for Medicare Part A or Part B.

Annual Open Enrollment Period



October 15 – December 7

- During the Open Enrollment Period you can:
 - Change prescription drug plans
 - Enroll in a drug plan for the first time
 - Drop Medicare drug coverage
 - Change from Original Medicare and a prescription drug plan to a Medicare Advantage plan
 - Keep your current coverage

Another opportunity to enroll is the Annual Open Enrollment Period each year from October 15 to December 7. During this time anyone on Medicare can:

- Enroll in a drug plan for the first time
- Drop drug plan coverage
- Change drug plans
- Change from a drug plan and original Medicare to a Medicare Advantage plan
- Change from a Medicare Advantage Plan to Original Medicare and a drug plan

If you do nothing during the annual open enrollment period to change plans, you will stay in your current plan.

Part D Special Enrollment Periods



- Loss of employer/retiree coverage
- Change in residence
- Moving into, residing in or leaving a long-term care facility
- Qualify for low income assistance
- Qualify for Medicaid coverage including help with Part B premium (Medicare Savings Plans)

There are other times you can enroll in or change Medicare prescription drug plans.

If you lose or voluntarily leave your employer or retiree coverage –this is called loss of creditable coverage.

Change in residence – if you move to a different state, you have 2 months from the date of the move to change to a PDP plan in that state. .

Moving into, residing in, or leaving a long-term care facility – get an SEP. (Those living in the facility can change plans anytime.)

- Qualify for “Extra help” – Anyone eligible for Extra Help gets a continuous special enrollment period to change plans monthly, if desired.
- Qualify for Medicaid, or a Medicare Savings Plan—continuous SEP to enroll and change plans

Special Considerations For Worker Or Spouse



If actively working, you may be able to delay enrollment into Part D until you retire

- Check if employer coverage is “creditable”
- Special enrollment period – 2 months after employer coverage ends

When you become eligible for Medicare, you may take Part A, but delay Part B because you or your spouse are going to keep working and have health insurance from that employer. You need to remember that Part D eligibility begins with enrollment in Part A and you need to enroll in a Part D plan at that time to avoid a penalty, unless you have creditable coverage with an employer plan. In that situation you can delay enrolling in Part D.

Creditable Coverage Notice



- Individuals receiving their prescription drug coverage from an employer, retiree or pre-standard Medicare supplement plan will receive a notice by October 15 each year telling them if their coverage is “as good as or better than Medicare coverage”.
- Keep this notice.

- Individuals receiving their prescription drug coverage from an employer (current or former) or union will receive an notice by October 15 each year telling them if their coverage is “as good as or better than Medicare coverage”. If coverage is creditable, you do not have to enroll in a Medicare Part D plan.
- Individuals who receive a notice saying their coverage is “as good as Medicare” don’t need to do anything except keep the notice with their important papers. These notices must be kept each year because you will need to prove you had creditable coverage every year to avoid paying a late enrollment penalty if you enroll in Part D at a later time.
- If they receive a notice that says their benefits are less than Medicare’s or benefits are being eliminated you will have 60 days from the date of the notice **OR** when their coverage ends, to enroll in a Part D drug plan to avoid having to pay a late enrollment penalty.

Part D Premiums



- Each plan has a monthly premium, set by the individual plan.
 - Premium can change from year to year
- Some people receive assistance paying the premium.
- Some people pay more than the plan's usual monthly premium if their income is above:
 - \$85,000 individual
 - \$170,000 couple filing a joint return

- Each drug plan has a monthly premium, which varies by plan. The premium is set each year and can change from one year to the next.
- The Part D premium is higher for individuals whose adjusted gross income is above \$85,000 (\$170,000 for couples), just like the Part B premium. Social Security will send a letter notifying them if they need to pay IRMAA.
- You pay this in addition to your regular Part D premium (including Part D coverage included in a Medicare Advantage plan).
- The IRMAA is withheld from your Social Security check. If you don't get a SS check, you will be billed for the IRMAA amount by Medicare. The money goes to Medicare, not to the Part D plan. This means you will get two bills—one from Medicare for IRMAA and one from your Part D plan for the regular Part D premium. If you don't have a Part D plan or a Medicare Advantage plan with drug coverage you will not pay IRMAA.

Individual tax return	Couple Filing Joint	IRMAA
\$85,000-\$107,000	\$170,000-\$214,000	\$13.30
\$107,001-\$160,00	\$214,001-\$320,000	\$34.20
\$160,001-\$214,000	\$320,001-\$428,000	\$55.20
Greater than \$214,000	Greater than \$428,000	\$76.20

Qualify For "Extra Help" With Prescription Drug Costs



- Helps pay premium, deductible and co-pays
- Monthly Income limits: Resource limits:
 \$1505 individual \$13,820 individual
 \$2022.50 couple \$27,600 couple

Apply through Social Security

SHIP can help!

• Individuals with limited incomes and resources may be able to get extra help with the costs of Medicare prescription drug coverage. You must enroll in a Medicare prescription drug plan to get the extra help.

• You can apply with the Social Security Administration

• When you apply, you will be asked for information about your income and resources and you will be asked to sign a statement that your answers are true.

• Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.

• When your application has been processed, you will get a letter telling you if you qualify for the extra help.

Certain groups of people automatically qualify for the extra help and do not have to apply. These include:

People with Medicare and full Medicaid benefits (including prescription drug coverage)

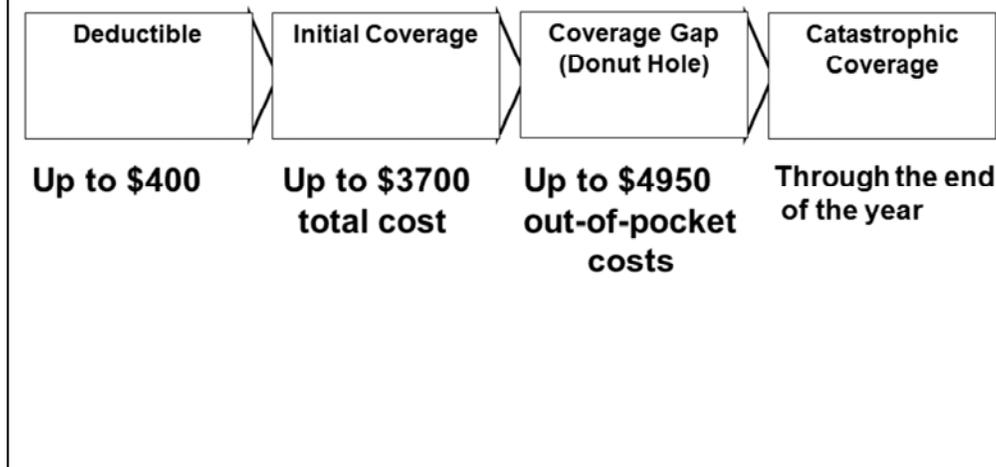
People with Medicare who get Supplemental Security Income only (SSI)

People who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs)

Standard Benefit-What You Pay



Understanding drug coverage stages



REFER TO: *Guide to Medicare Prescription Drug Coverage*

Let's talk about the drug coverage stages and how they work.

If a plan has a deductible, you pay the total cost of your medications at the pharmacy, until you reach the deductible amount. Then you move to the initial coverage stage.

Once the initial drug coverage stage begins, you pay a flat fee (co-pay) or a percentage of the drug's total cost (co-insurance) for each prescription that is filled. The plan pays the rest until total drug costs reach \$3700 for 2017.

If total drug costs go beyond \$3700, you reach the coverage gap or "donut hole". During this stage, in 2017, you will pay 40% of the costs of brand-name drugs and 51% of the cost of generic drugs. The manufacturer of brand name drugs absorbs 50% of the cost of brand-name medications, and the plan pays the rest of the costs for brand-name and generic drugs.

Once your out-of-pocket costs – what you have paid plus the 50% cost of brand-name drugs that the manufacturer contributes – reach \$4950 in 2017, you reach the catastrophic drug coverage stage. In this stage, you pay a small co-pay or co-insurance amount for each prescription. The plan pays the rest until the end of the calendar year.

Out-of-pocket costs do not include the monthly premium that you pay.

Comparing Part D Plans



- Premium
- Deductible
- Formulary – the drugs that are covered
- Restrictions on your medications
- Out of pocket costs at pharmacy
- Coverage in the Gap
- Pharmacy network (national availability?)

- When you are comparing Part D plans, look at
 - Premium
 - Deductible – How much do you pay toward your prescription drug costs before the Medicare drug plan pays benefits?
 - Formulary – Does the plan cover all the medications you are taking? If not, does it cover the most expensive ones? Each plan will have its own formulary (list of drugs) it covers.
 - Are there any restrictions on the drugs you take - for example: quantity limits, step therapy or prior authorization?
 - Cost – How much will you pay for your prescriptions? Most Medicare drug plans have a tiered formulary. This means your share of the costs will vary depending on the drug.
 - Coverage in the Gap – Does your plan cover any of your drugs in the gap or will you pay full price for your drugs?
 - Pharmacy – Can you fill your prescriptions at the pharmacy you use regularly?
 - Can you fill your prescriptions when you travel?

How Do You Compare Plans?



Information is Online

www.medicare.gov



SHIP can help you compare plans

- **The best way to compare plans is to use the Plan Finder Tool on www.medicare.gov.**
- **If you do not have access to a computer**
 - **Maybe a family member or friend would help**
 - **1-800-Medicare**
 - **SHIP counselors**
 - **Other agencies**



To compare plans on Medicare.gov, start here with “Find Health and Drug plans”. On the next screen, you will enter information about yourself and then you will come to a page where you enter your medications. You can then select your pharmacy, and the plans will be listed for you in order of least expensive to most expensive. Clicking on the name of the drug plan will bring up further detail.

You can also enroll in a plan from the Medicare website.

Your Medicare Coverage Choices

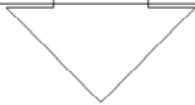


Original Medicare

Part A Hospital Insurance
Part B Medical Insurance

Supplemental coverage

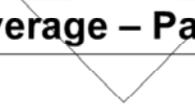
Prescription Drug
Coverage – Part D



Medicare Advantage Part C

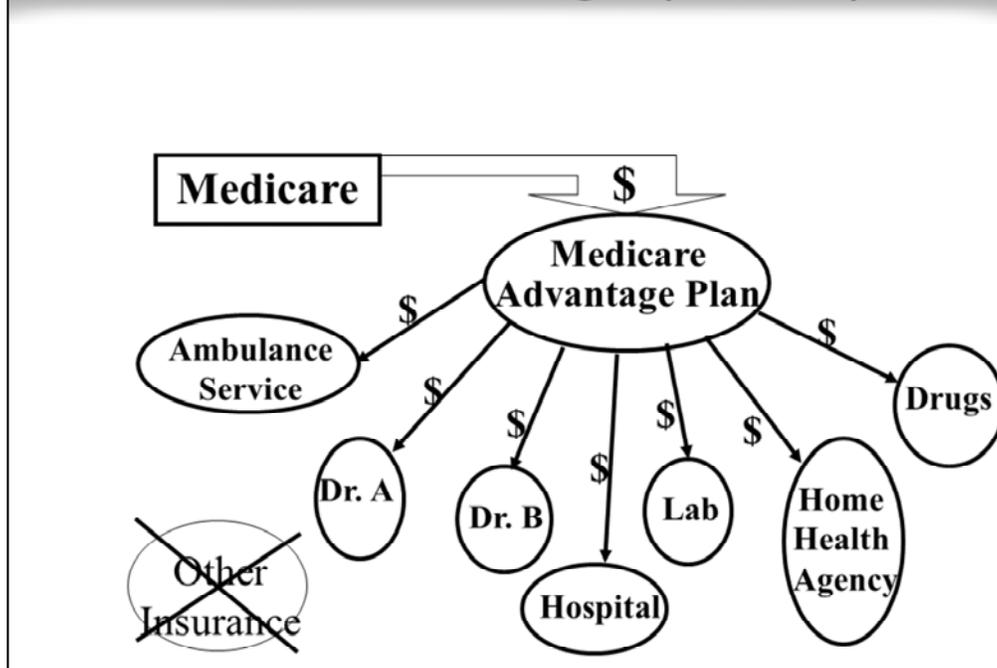
Combines Part A &
Part B

May include
Prescription Drug
Coverage – Part D



- Next we will discuss Medicare Advantage plans., the second way to get your Medicare benefits.

Medicare Advantage (Part C)



REFER TO: *Medicare Advantage and Other Health Plans in Iowa 2017*

- Medicare Advantage Plans are health plan options that are approved by Medicare and run by private companies who have a contract with Medicare.
- These plans are part of the Medicare program, and are sometimes called “Part C.”
- Medicare Advantage Plans provide Medicare-covered Part A & B benefits to members through the plan, and may offer extra benefits that Medicare doesn’t cover, such as vision or dental services. Often, they also include prescription drug coverage.
- When you enroll in a Medicare Advantage plan, you still have Medicare coverage but you are no longer in original Medicare. You are opting to buy your Medicare Part A&B coverage through a private company.

Medicare Advantage - A Private Solution



- Medicare contracts with a private company on an annual basis.
- Contracts require that plans provide Medicare Part A & B services.
- The plan handles claims.
- You receive services and make payments based on the private plan's rules.
- The plan may offer extra coverages – dental, vision, health club membership

When someone enrolls in a Medicare Advantage plan, Medicare pays a set amount to the plan to provide your health care benefits.

- All claims from providers go to the Medicare Advantage plan directly. The plan pays the claims. Claims are not sent to Medicare.
- You will receive services and make payments based on the plan's rules, not the way original Medicare pays.
- You will have a card from the Medicare Advantage plan and it is this card you show when you get care from a hospital or other provider, not your Medicare card. If the plan includes drug coverage, you also use your card at the pharmacy.
- Important: Do not discard your original red, white and blue Medicare card. You will need it if you ever change to a different Medicare Advantage plan or return to original Medicare.
- Medicare Advantage plans contract with Medicare on an annual basis. Each calendar year, the plan can decide to drop their contract with Medicare or to change their benefits, premiums, deductibles, and co-payments.

Questions to Ask About MA Plans



- Do I live in the service area for the plan?
- Will my doctors, hospital and other medical providers accept payment from the MA plan?

The main differences between having coverage through original Medicare vs a Medicare Advantage plan are: networks of providers, out-of-pocket cost and rules for accessing care.

- Medicare Advantage plans have networks. Original Medicare can be used nationwide, with any provider who has a Medicare number. In a specific Medicare Advantage plans coverage may not be available in all parts of the US. However, you have the right to get urgent or emergency care anywhere in the United States when you need it, without any prior approval from the plan.
- Your doctor may be in-network for one Medicare Advantage plan, but not for another..
- Medicare Advantage plans have service areas, typically counties. You must buy a plan that is sold in the county in which you live.

Questions to Ask About MA Plans



- What is the monthly premium?
- What is the annual out-of-pocket maximum?
- What are the deductibles, co-payments or coinsurance for the benefits I'm most likely to use?
- Does the plan include prescription drug coverage

Out of pocket costs for health care are different between original Medicare and Medicare Advantage plans. With original Medicare and a supplement, you will typically have a higher monthly premium, but less costs when using care. With a Medicare Advantage plan, the premium may be as little as zero, but you will have costs each time you use medical services.

Look at the plan's annual out-of-pocket maximum., which may vary by several thousand dollars among plans. The maximum OOP in 2017 is \$6700. The OOP maximum includes costs you pay for health care, not co-payments or deductibles for prescriptions.

Look at the costs for the benefits you are most likely to use. Do you visit a specialist regularly? Are you planning surgery with a possible stay in a Skilled Nursing Facility afterward for rehabilitation?

You cannot buy supplemental coverage to pay for these out-of-pocket costs.

Medicare Advantage - Out-of-Pocket Costs



- Must still pay Part B premium
- May pay additional monthly premium
- Pay other out-of-pocket costs
 - Different from Original Medicare Plan
 - Vary from plan to plan

If you join a Medicare Advantage Plan, it's important to know:

- You must continue to pay the monthly Medicare Part B premium (\$134 in 2017).
- You may pay an additional monthly premium to the plan.
- You will have to pay other costs (such as copayments or coinsurance) for the services you get. Out-of-pocket costs in these plans may be lower than in the Original Medicare Plan (without a Supplement) .

Medicare Advantage - Types of Plans



- HMO-Health Maintenance Organization
- PPO-Preferred Provider Organization
- Private Fee-For-Service
- Cost Plan

Medicare Advantage plans can have different types of networks. It is important that you understand which type of Medicare Advantage plan you are in, and what the rules are for accessing care.

Medicare HMO



- Check that your providers will accept the plan.
- Generally must get care and services from plan's network
- May have to pay full cost of care outside of plan's network
- May need to choose primary care doctor
- Need referral to see a specialist

REFER TO: Page 12-18 of *Medicare Advantage and Other Health Plans in Iowa 2017*

In Medicare HMOs, you generally must get your healthcare from providers who are in the plan's network. You may be asked to choose a primary care doctor. The primary care doctor is the doctor you see first for most health problems. You usually need a referral to see a specialist (such as a cardiologist.)

If you get health care outside of the plan's network, except in urgent or emergency situations, neither the Medicare HMO nor original Medicare will pay for these services.

Call the plan to see which doctors and hospitals are in the plan's network. You can often find this information on the plan's website.

For a doctor or hospital to be in a plan's network, there is a contract between the plan and the provider. These contracts can end at times of the year other than December 31, and either party can decide not to continue the contract. If you are enrolled in a Medicare Advantage HMO and your doctor leaves that plan's network, you will need to select a different provider.

If you want Part D coverage, you must select an HMO plan that includes it; you cannot buy a stand-alone Prescription Drug Plan to

go with a Medicare Advantage HMO.

Medicare PPO



- There are in-network and out-of-network providers.
- Co-payments are set by the plan.
 - Usually higher for out-of-network care
- You don't need a referral to see an out-of-network provider.
- An out-of-network provider does not have to accept your PPO plan.
 - You don't need a referral to see a specialist.

REFER TO: Pages 20-25 of *Medicare Advantage and Other Health Plans in Iowa 2017*

A PPO has both in-network and out-of-network providers.

Costs will be lower if you go to an in-network provider.

You can go to an out-of-network provider, who is willing to submit claims to the plan. Your costs will be higher.

Out-of-network providers have to provide emergency or urgent care but do not have to agree to accept your PPO for non-emergency, non-urgent care.

You don't need a referral to see a specialist.

If you want Part D coverage, you must get it in the PPO plan. You cannot buy a stand-alone Prescription Drug Plan to accompany a PPO.

Medicare PFFS



- Check that your providers will accept the plan before receiving care
- Understand when you can change plans
- If plan does not include drug coverage, you can add a stand-alone Medicare Prescription Drug plan

REFER TO: Pages 26-27 of *Medicare Advantage and Other Health Plans in Iowa 2017*

- You can choose which provider you will see, do not need a referral to see a specialist, and can get services outside your service area. While you can go to any Medicare-approved doctor or hospital, that provider must agree to accept the terms of their plan's payment.
- If you enroll in a Medicare PFFS that does not offer drug coverage, you can also enroll in a stand-alone prescription drug plan.

Medicare Advantage - Eligibility



- Have Medicare Parts A & B
- Do not have end-stage renal disease
- Live in service area (county-specific)
- Covers people on Medicare because of disability

Medicare Advantage plans are available to most people with Medicare. The only people who do not qualify are those with End Stage Renal Disease (ESRD).

To be eligible to join a Medicare Advantage Plan, you must:

- Live in the plan's geographic service area
- Have Medicare Part A and Part B

When Can You Join?



- You can join a Medicare Advantage Plan or other Medicare plan
 - During your Initial Enrollment Period – when you are first eligible for Medicare
 - Each year, during Open Enrollment Period (October 15 - December 7)
 - During a Special Enrollment Period

REFER TO: Page 5 of *Medicare Advantage and Other Health Plans in Iowa 2017*

You can join a Medicare Advantage Plan or other Medicare plan when

- you first become eligible for Medicare (i.e., Initial Enrollment Period) or
- at any time a plan is allowing new members to join, which may be during the annual Open Enrollment Period (October 15- December 7) and in certain special situations.

Generally, enrollment in a plan is for a year. You can only join one plan at a time.

Open Enrollment Period	
October 15 – December 7	
Can choose new plan	
Medicare Advantage Plan	
Medicare Prescription Drug Plan	
Original Medicare	
New plan starts January 1	

REFER TO: Page 5 of *Medicare Advantage and Other Health Plans in Iowa 2016*

- Every year from October 15 – December 7, you will be able to choose which Medicare Advantage Plan or other Medicare plan you want to join for the upcoming year.
- You can also decide during Open Enrollment to go back to original Medicare and you can enroll in a Medicare Prescription Drug Plan.
- Your new plan will start the following January 1.

Special Enrollment Periods



- Move out of the plan's service area
- Loss of employer/retiree coverage
- Moving into, residing in or leaving a long-term care facility
- Qualify for "Extra Help"
- Qualify for Medicaid coverage including help with Part B premium (Medicare Savings Plans)

These special enrollment periods are the same ones that apply to enrolling in a Medicare prescription drug plan, which we have already discussed.
(Slide 48)

Medicare Advantage - Disenrollment Period



- January 1 – February 14 each year:
 - Can return to original Medicare
 - Can enroll in a stand alone Part D drug plan
- Change effective first day of following month
- Does not give you a guaranteed right to purchase a Medicare Supplement without answering health questions

• There is also a “disenrollment period” for Medicare Advantage. The Medicare Advantage disenrollment period is the first 45 days of the year. The disenrollment period will allow individuals enrolled in a Medicare Advantage plan to return to Original Medicare and enroll in a stand-alone Part D drug plan if desired.

• You cannot use the disenrollment period to change to a different Medicare Advantage plan.

• Disenrolling from a Medicare Advantage plan does not give you a guaranteed right to purchase a Medicare Supplement without answering health questions.

“Trying Out” A Medicare Advantage Plan



- If you enroll in a Medicare Advantage plan when you first enroll in Medicare part B at age 65
- AND
- You disenroll from the Medicare Advantage plan within 12 months
- THEN
- You will be able to get a Medicare Supplement without answering health questions

REFER TO: Page 6 of *Medicare Advantage and Other Health Plans in Iowa 2017*

If you are enrolling in a Medicare Advantage plan for the first time you can return to Original Medicare and are guaranteed the right to get Medicare Supplement Insurance in this situation.

1. You enroll in a Medicare Advantage plan the first time you enroll in Medicare Part B **at age 65**. Then you disenroll **within the first 12 months**.

You must be allowed to enroll in ANY Medicare supplement plan, **A through N**, offered by ANY COMPANY selling those plans in Iowa.



Another Medicare resource is www.mymedicare.gov. This web site is your personal Medicare web site. Any time of the day you can go to this website and

- Track your Medicare health care claims
- Check you Part B deductible status
- View your eligibility information
- Track the preventive services you can use and when you used them last
- Find your Medicare health or prescription plan,

- Directions to sign up are found on the last page of the *Medicare Preventive Benefits* factsheet.

Health Insurance Marketplace



If I have Medicare, do I need to do anything about the Health Insurance Marketplace?

- Medicare isn't part of the Marketplace
- If you have Medicare, you are covered and don't need a Marketplace plan

If you have a Marketplace plan before you enroll in Medicare:

- Cancel your Marketplace plan when Medicare begins
- Any premium tax credit and reduced cost-sharing will end when Medicare starts

If you have Medicare, you do not need to do anything about the Health Insurance Marketplace (part of the Affordable Care Act).

The Marketplace won't affect your Medicare choices or benefits.

If you have a Marketplace plan before you enroll in Medicare, cancel it when your Medicare begins.

Marketplace plans are not designed to coordinate with Medicare.

Any premium tax credits or reduced cost-sharing you qualify for in the Marketplace, will end when Medicare starts.

Drug coverage provided in a Marketplace plan is not creditable.

If you stay in your Marketplace plan after you are eligible for Medicare, instead of enrolling in Medicare, you may have a penalty when you later enroll in Medicare Part B or Medicare

prescription drug coverage.

Contacting SHIP



- Statewide: 1-800-351-4664
(TTY 1-800-735-2942)
- Website: www.therightcalliowa.gov
- E-mail: shiip@iid.iowa.gov
- Local: Check Website or
call toll-free

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Volunteering for SHIP



- A challenging and rewarding opportunity to help lowans on Medicare
- Be a counselor, computer volunteer, member of our speakers bureau/help promote SHIP
- For more information call SHIP at 1-800-351-4664

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SHIIP PRESENTATION FEEDBACK					
Program	_____				
Date	_____	Location	_____		
Please use the following scale: (circle appropriate number)		Strongly Agree	Agree	Disagree	Strongly Disagree
Presenter/Method					
1.	The presenter was knowledgeable	4	3	2	1
2.	The presenter kept my interest	4	3	2	1
3.	The presenter was effective communicating the information	4	3	2	1
4.	The visual aids/handouts added to the presentation	4	3	2	1
Participant Benefits					
5.	The presentation met my expectations	4	3	2	1
6.	My knowledge of the subject has increased	4	3	2	1
Status					
7.	Currently enrolled in Medicare _____	Preparing for Medicare	_____		
	Expected Medicare Effective date _____				
Other					
8.	How did you hear about this presentation? _____				
9.	Is there information you would like to have added to the presentation? If so, please list. _____				
10.	Please have someone call me to set up an individual appointment with SHIIP Counselor. (Please provide your name and phone number below). _____ Yes ___ No				
11.	I would like someone to contact me about volunteering for SHIIP. (Please provide your name and email address below) _____ Yes ___ No				
	Name: _____	Phone #	_____		
	Email Address: _____				
	Comments: _____				

Thank you for coming.

Please complete your evaluation form and leave it _____