

Show Me Guide

Medicare Made Clear™

Get Answers: Medicare Education



**An easy-to-use reference for understanding
your Medicare options.**

Look inside to:

- Understand the differences between Medicare plans
- Compare plan types and choose the right one for you
- Understand enrollment windows and timing
- Find Medicare resources



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A note about numbers

This guide provides information about Medicare costs such as premiums and deductibles. Many of these costs will change from year to year. For the most current figures, call the Medicare Helpline. ► Page 58

This guide also gives many examples of costs for specific treatments or for premiums for private plans. These costs vary from plan to plan and from state to state. Your specific costs will vary.

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Getting started

The Medicare program helps nearly 50 million Americans get the health care they need. That's a good thing. Just as important, Medicare offers you choices about how you can receive your benefits. You can find a solution that fits your needs, whatever they may be.

But choosing Medicare coverage can sometimes seem difficult. You know this choice is important to both your health and your budget, and you want to do a good job. This decision is important, but you've made important decisions before. You'll have to spend some time studying your choices, but, in the end, you can find a solution that's right for you.

UnitedHealthcare® created this guide to introduce you to the choices that are available and will explain the important differences. It's not a comprehensive guide to every nook and cranny of the choices you have, but it will help give you a solid foundation for understanding them.

Why is this decision so important? Because health care costs are a big part of the budget for many people. It's a fact of life — we've made amazing advances in medicine in the last 50 years, but they come with a big price tag. Medicare offers help with these costs. But making the right choice for you will take some thoughtful planning.



Tip

A word to the wise: Don't wait until later to learn about your options. If you wait, you may have fewer choices, and you may pay more. If you're approaching 65 or have otherwise recently become eligible for Medicare, read this *Show Me Guide* now. It can help you decide which type of plan best meets your needs.

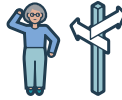
What are the big ideas?

10 tips about Medicare

The details of Medicare can be complicated, but you can master the big ideas in a few minutes. Here's a quick look at 10 important ideas you need to know.

1

There are two main ways to get Medicare.



- You can choose Original Medicare (Parts A and B), which is provided by the federal government
- Or you can choose a Medicare Advantage plan (Part C). These plans are offered through private insurance companies

2

With Original Medicare, you'll pay a share of the cost.



- You contributed to Medicare by paying taxes. That's why you're eligible for Medicare when you turn 65
- Original Medicare doesn't pay for everything. You still pay a share of the cost in monthly premiums and co-pays

3

Medicare supplement insurance helps control out-of-pocket costs.



It helps with some of the expenses Medicare Parts A and B don't pay, like co-pays and deductibles.

4

Prescription drug coverage helps limit drug costs.



As a Medicare member you can get optional prescription drug coverage (Part D).

- You can enroll in a stand-alone Part D plan to go with your Original Medicare coverage
- Or you can enroll in a Medicare Advantage plan that includes prescription drug coverage

5

Know the choices in your state.



- Original Medicare (Parts A and B) is the same across the United States
- Medicare Advantage (Part C) and prescription drug (Part D) plans are offered by private insurance companies and may be available only in certain counties, states or regions
- Medicare supplement policies offer nationwide coverage and are available by state

6

Enroll at the right time.



Your initial enrollment period (IEP) is your first chance to enroll in Medicare. It's the three months before your 65th birthday month, the month of your birthday, and the three months after your birthday month.

- If you enroll before the month you turn 65, coverage starts on the first day of your birthday month
- If you enroll during your birthday month or later, coverage starts on the first day of the month following the date you enroll



Tip Important:

If you don't sign up for Part D coverage when you enroll in Medicare, you may pay a penalty if you enroll later unless you qualify for an exception.

7

Review your choices once a year.

After you choose your Medicare coverage, you can make changes each year during the Medicare Open Enrollment Period (OEP), October 15 – December 7. Review your coverage to see if it still fits your needs. Keep in mind there may be limitations to rejoining a Medicare employer-sponsored plan.



8

Special Election Period (SEP)

In some cases you may be able to enroll in, or switch, plans outside of the IEP and OEP. This includes changes in your life situation, such as:

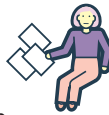


- You retire and leave a health care plan through your employer or union
- You move out of your current health plan's service area

9

Review your current coverage.

For example, if you have group coverage from your job, or retiree insurance from a former employer, you'll want to see how it fits with Medicare.



10

Help is available.

Medicare can be complicated, but help is available. You may even qualify for financial help. For more details, see page 58.



Medicare doesn't cover everything.

Medicare doesn't cover all of the care you might possibly need. Each part of Medicare has exclusions, or things it doesn't cover. For example, Medicare doesn't cover long-term care.

What's not covered by Original Medicare?

Here are some things Medicare doesn't cover.



Most dental care



Routine eye care



Routine hearing tests



Most care while traveling outside the United States



Custodial care (help with bathing, dressing, eating, etc.)



Long-term care



Cosmetic surgery



Most chiropractic services



Routine foot care



Acupuncture

Getting ready for Medicare

This *Show Me Guide* is meant for people who are about to join Medicare for the first time. It also has information that may help people who are already enrolled in Medicare but still have questions.

As you get ready to join Medicare, it helps to know a little about when you become eligible for Medicare and who handles the paperwork when you join.

When am I eligible?

You're eligible to join Medicare if this describes you:



- 1 You are 65 years old, or you are under 65 and qualify on the basis of disability or other special situation.

- 2 You are a U.S. citizen or a legal resident who has lived in the United States for at least five consecutive years.

Here are some things to know about the "age 65" rule.

Even if you're already collecting Social Security, you must wait until you're 65.



You must be 65. Your spouse's age doesn't count.

Even if you're not collecting Social Security yet, you're eligible at age 65.

If you have questions about when you will be eligible for Medicare, visit **Medicare.gov**, or call your local Social Security Administration office for more information (see resources on page 58).

How do I get started?

You must initiate the enrollment process with Social Security. Go online, call or visit your local Social Security office to get the process started. The Social Security Administration handles most of the paperwork for joining Medicare. The first letter you get in the mail about Medicare will probably come from Social Security. If you're drawing Social Security benefits when you turn 65, Social Security should automatically enroll you in Medicare Part A and Part B but check with your local Social Security office if you suspect there is a problem.

Social Security can also help you find out if you're eligible for extra help with the cost of Medicare coverage. For more about enrolling in Medicare and getting extra help with Medicare costs, see pages 43 and 44.

What happens to the health coverage I have now?

As you make your decisions about Medicare, keep your current health coverage in mind. This could be retiree health coverage from your former employer or your union, if you've retired. If you're still working, you may have health coverage from your current job. Or you may have purchased your own health insurance.

You'll need to find out whether you can keep any coverage you currently have and what your costs might be. You may have more choices available to you than the standard choices described in this guide.

Explore your options with someone who's familiar with the details of the coverage you have now. If it's coverage from an employer or a union, you can start with a human resources manager or a benefits specialist. Or talk to customer service at the insurance company that provides the plan. Do your research. In some cases, if you keep your current coverage and wait until later to join Medicare, you may have fewer choices and pay more.



Tip

This guide gives you a solid foundation for shopping for Medicare coverage, but it can't help you pick specific plans. For that, you'll need to compare your health care and budget needs with what the individual plans have to offer. For more information, see page 58.

What you need to decide

Your biggest decision, and the one to make first, is whether you want Original Medicare (Part A and Part B) or Medicare Advantage (Part C). They cover the same basic services, but they work differently. Your choice depends on what you need. This guide will help you understand what you're choosing.



Once you decide, you'll have other choices to make. If you choose Medicare Advantage, you'll have to pick a specific plan from a particular company. If you choose Original Medicare, you'll have more choices. You'll need to choose from several companies and plans if you want to buy a Medicare supplement policy or stand-alone drug plan.

Medicare Choices

Step 1

Enroll in Original Medicare when you become eligible.

ORIGINAL MEDICARE

 **PART A** +  **PART B**

Covers hospital stays Covers doctor and outpatient visits

Government-provided

Step 2

If you need more coverage, you have choices.


Option 1

or

Option 2

Keep Original Medicare and add:

MEDICARE SUPPLEMENT INSURANCE




Covers some or all of the costs not covered by Parts A & B

Offered by private companies

and/or

MEDICARE PART D



Covers prescription drugs

Offered by private companies

MEDICARE ADVANTAGE (PART C)

 Combines Parts A & B

 Additional benefits

 Most plans cover prescription drugs

Offered by private companies

How does cost sharing work?

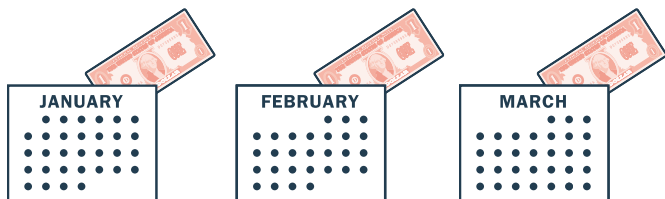
Four words you've got to know

Understanding how Medicare shares costs is a big part of choosing the right Medicare benefits for you. You'll meet four words over and over again in this guide: **premium, deductible, co-pay, co-insurance**. These words have special meanings in Medicare, and mastering them will pay off. The words are names for different methods that Medicare uses to share the cost of your care with you. Medicare's reasoning is simple. If you pay some of the cost of the health care you use, you will use it more carefully. And you'll be encouraged to do things that help keep you healthy and that may reduce your need for medical care.

1

Premium

Premium is a fixed amount you have to pay to participate. Most Medicare premiums are charged by the month.

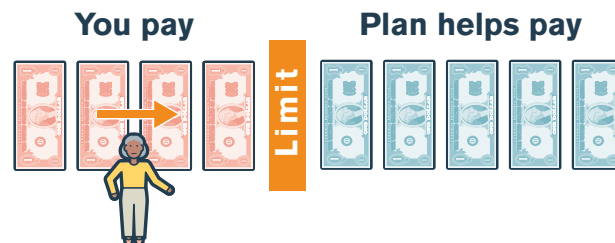


Cost-sharing methods

2

Deductible

Deductible is a preset amount that you have to pay first, before Medicare or a private insurance company begins to help with your costs.



3

Co-payment

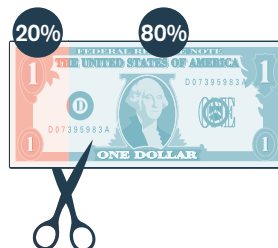
Co-payment is a fixed amount that you pay, like \$10, for a service or product. Some people call this a "co-pay."



4

Co-insurance

Co-insurance is splitting your health care costs with the plan on a percentage basis. For example, you pay 20% and the plan pays the remaining 80%.



Tip

It's easy to focus only on your premium amount when you shop for plans and policies. But you should also look at how much you'll spend on cost sharing (deductibles, co-pays and co-insurance). Sometimes a plan with a lower premium could cost you more because it has higher cost sharing for the services you use. Remember that the Medicare premiums, deductibles and co-pays shown in this guide are accurate for 2016, but may change from year to year.

A look at what's coming up

What you'll find in this book

ORIGINAL MEDICARE



Government-provided

Medicare Part A

Help with hospital care.

► Pages 10–13

ORIGINAL MEDICARE



Government-provided

Medicare Part B

Help with doctor's visits and outpatient care. ► Pages 14–17

MEDICARE ADVANTAGE (PART C)



Offered by private companies

Medicare Part C

(also called Medicare Advantage)
Plans that combine the services of Part A and Part B, and often Medicare Part D. ► Pages 18–29

MEDICARE PART D



Offered by private companies

Medicare Part D

Help with prescription drugs in either of two ways — voluntary enrollment in a stand-alone Medicare Part D plan, or a Part C (Medicare Advantage) plan that offers prescription drug coverage. ► Pages 30–35

MEDICARE SUPPLEMENT INSURANCE



Offered by private companies

Medicare supplement insurance

(also called Medigap) Not a part of Medicare, but designed to help you reduce your medical expenses in Medicare Part A and Part B.

► Pages 36–39

What's a "Part"?

Wondering what a Part is? It's just a name Congress used to label sections of the law that created Medicare. They could have said "Chapter" or "Section," but they chose "Part."

Overview of Medicare Part A

Big idea

Provide help with the cost of inpatient hospital stays and skilled nursing services following a hospital stay, plus some other skilled care

Description

Medicare Part A insurance helps pay for “medically necessary” care (care for an illness or medical condition) that involves an inpatient stay in the hospital. Part A also helps pay for a stay in a skilled nursing facility as a follow-up to a hospital stay, hospice care for the terminally ill and some skilled home health care for the homebound. Part A also helps pay for some blood transfusions.

What providers can I see?

You can choose any qualified provider in the United States who has been accepted by Medicare and who is accepting new patients. Because Part A offers the same benefits throughout the United States, you are not limited to a particular state or region for your care.

Coverage limits

If you are hospitalized for a very long time (more than 90 days at one time), there are limits on the number of days of care that Part A will help pay for.

In the same way, there are limits on the number of days of care in a skilled nursing facility that Part A will help pay for. Part A pays for an unlimited number of skilled home health care visits, or hospice care visits, but you must meet certain conditions to receive either kind of help.

What won't I get help with?

Part A helps you pay the costs of hospital care when you're sick. But there are some things it won't pay. Most doctor services you receive in the hospital are covered by Part B, and you'll have to pay the Part B deductible and 20% co-insurance. Part A won't pay personal costs in the hospital, like charges for a television or telephone calls. It also doesn't help with the cost of “custodial care.” This is care that helps with the activities of daily life, like eating, bathing or

dressing. Custodial care doesn't require the kind of skilled medical care provided in a hospital or skilled nursing facility, so Part A does not cover it.

For more information about where to find custodial care, see page 58.

What's covered by Part A?



A semi-private room



Your hospital meals



Skilled nursing services



Care on special units, such as intensive care



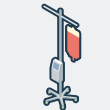
Drugs, medical supplies and medical equipment as an inpatient



Lab tests, X-rays and radiation treatment as an inpatient



Operating room and recovery room services



Some blood for transfusions in hospital or skilled nursing facility



Rehabilitation services, such as physical therapy received through home health care



Skilled health care in your home if you're homebound and only need part-time care



Care to manage symptoms and control pain for the terminally ill (“hospice care”)

Costs

Premium

Part A is premium free if you or your spouse have made payroll contributions to Social Security for at least 10 years (40 quarters).

If you otherwise qualify for Medicare but neither you nor your spouse has contributed to Social Security for at least 10 years, you'll pay a monthly premium up to \$411 per month in 2016.

If you must pay a premium for Part A and you don't enroll in Part A when you become eligible for Medicare, your premium could be higher if you sign up later.

Cost sharing

Deductible

Before Part A begins paying a share of your costs, you must first pay a deductible. In 2016, your Part A deductible is \$1,288. You'll pay this deductible for each hospital stay, subject to certain limits.

Co-pay

You pay a co-pay after you have stayed a certain number of days. For hospital stays, you'll pay \$322 (2016) per day for days 61 through 90, and \$644 (2016) per day for days 91 through 150. In a skilled nursing facility, you'll pay \$161 (2016) per day for days 21 through 100 that you stay.

You'll also pay a co-pay of \$5 (2016) for each outpatient drug prescription you receive in hospice care.

Co-insurance

You will pay a small co-insurance payment if you use inpatient respite care for hospice patients.

Enrollment

When can I join Part A?

As soon as you become eligible for Medicare, you can join Part A. Just sign up in your "initial enrollment period." You can also join later on, but only at certain times of the year, unless you qualify for an exception. ► Page 44

How do I sign up?

If you are receiving Social Security benefits when you become eligible, you should automatically be enrolled in Parts A and B, but check with your local Social Security office if you suspect there is a problem.

If you're not receiving Social Security benefits, you can sign up for Part A at your local Social Security office.

Can Part A refuse to cover me or delay coverage?

Assuming you are eligible for Medicare, you can't be refused Part A because of your medical history or a pre-existing illness. The time when your coverage begins depends on when you sign up. If you sign up promptly at the start of your initial enrollment period, your coverage will begin on the first day of the month you become eligible.

How does renewal work?

Your Part A coverage renews automatically from year to year. You don't have to do anything.

Your share of Part A costs

Part A pays most of the cost of hospital stays lasting up to 60 days. But if you have a very long stay, you should expect to pay a large share of the cost.

What's my share?

In Part A, you'll pay a deductible for each "benefit period." You'll also pay a daily co-pay after the 60th day of a long hospital stay.

How does this work?

A benefit period begins when you enter the hospital and ends when you have been out of the hospital for 60 days in a row. If you're in and out of the hospital several times within a few weeks for the same condition, that's still one benefit period.

In 2016, the deductible is \$1,288. In addition, if your hospital stay lasts longer than 60 days in a benefit period, you'll pay a substantial co-pay for each day between 61 and 150.

Part A limits the number of long hospital stays (stays of more than 90 days) it will pay for. When you join Part A, you'll get a "lifetime reserve" of 60 days. Each time you stay in a hospital more than 90 days, you can use lifetime reserve days to cover the number of days you stay beyond 90.

Once you've used up your lifetime reserve (60 days), Part A will pay only for the first 90 days of any hospital stay. And that's subject to the normal deductibles and co-pays. After 90 days, you're responsible for paying for your own care. To see how this works, look at Juan's example. ▶ Page 13

Part A also limits the number of days in a psychiatric hospital it will pay for in your lifetime.

Example: a brief stay

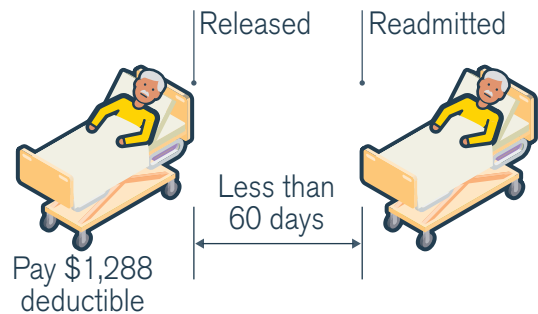


Pay \$1,288 deductible

Julie spends three days in the hospital.

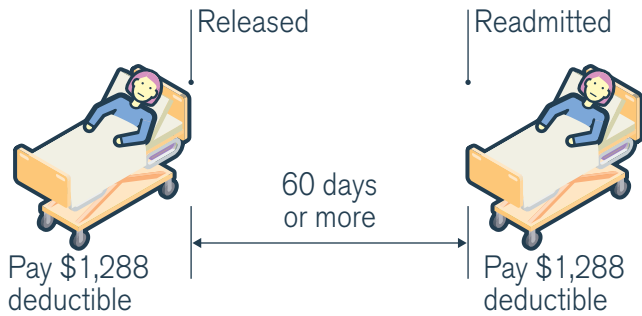
Deductible	\$1,288
Days 1 to 3	\$0
Total Julie pays	\$1,288*

Example: a single benefit period



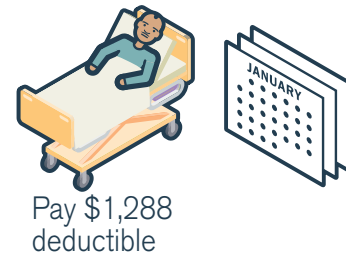
Hector stayed in the hospital 5 days in December. He was readmitted in early February and stayed for 3 days. Hector wasn't out of the hospital for 60 days before he went back to the hospital in early February, so his 8 days are all in a single benefit period. He only pays his deductible once.

Deductible	\$1,288
Days 1 to 5 and 6 to 8	\$0
Total Hector pays	\$1,288*

Example: two separate benefit periods


Margaret stayed in the hospital 5 days in January. She was readmitted in September and stayed for 65 days. Because she was out of the hospital more than 60 days, her second stay began a new benefit period.

Deductible 1 (January)	\$1,288
Days 1 to 5	\$0
Deductible 2 (September)	\$1,288
Days 1 to 60	\$0
Days 61 to 65 (5 days at \$322 each)	\$1,610
Total Margaret pays	\$4,186*

Example: long hospital stay


Juan stayed in the hospital 185 days before his doctors felt they could release him. Part A stops paying for Juan's care after day 150 because he has used up all of his lifetime reserve days, and he has no Part A coverage left. The hospital's charges for days 151 to 185 are \$1,200 per day.

Deductible	\$1,288
Days 0 to 60	\$0
Days 61 to 90 (30 days at \$322 each)	\$9,660
Days 91 to 150 (60 days at \$644 each)	\$38,640
Days 151 to 180 (35 days at \$1,200 each)	\$42,000
Total Juan pays	\$91,588*

*These examples show hospital charges only. There may be additional cost sharing for services such as physicians, laboratory and radiology.

Overview of Medicare Part B

Big idea

Provide help with the cost of doctor visits and other medical services

Description

Medicare Part B insurance helps pay for a variety of medically necessary care — that is, care for an illness or medical condition. This includes services like doctor's office visits, care in hospitals and clinics when you are not admitted for an inpatient stay, laboratory tests and some diagnostic screenings, and some skilled nursing care at home, if you're homebound.

Part B also covers most doctor services you receive as a hospital inpatient, although other hospital services are covered by Part A. Part B is voluntary, but most people sign up when they first become eligible.

Medicare Part B is making it easier to get preventive care. It now covers an annual wellness exam plus additional preventive screenings at no cost to you.

What providers can I see?

You can choose any provider who is eligible to participate in Medicare, and who is accepting new patients.

Coverage limits

As a general rule, Part B doesn't limit the number of Part B services you can receive, as long as your care is medically necessary to treat an illness or condition. However, there are limits on a few services. For example, there are limits on the amount Part B will pay in a single year for occupational therapy and speech therapy. Some preventive care and screenings are only covered at specific intervals, like once a year for a flu shot.

Part B offers the same benefits throughout the United States. You are not limited to a particular state or region for your care.

What won't I get help with?

Part B focuses on helping you pay the costs of medically necessary care when you're sick. Only in very limited situations does it cover any care for your eyes, teeth or hearing.

Part B does not cover medical care you receive outside the United States, except in a few very limited situations.

Part B also doesn't cover the cost of help with the activities of daily life, like eating, bathing or getting dressed.

What's covered by Part B?



Doctor's visits (including an annual wellness exam)



Ambulatory surgery center services



Outpatient medical services



Some preventive care, like flu shots and pneumonia shots



Clinical laboratory services (blood tests, urinalysis, etc.)



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



Some diagnostic screenings, like colorectal and prostate cancer screenings and mammograms



Durable medical equipment for use at home (oxygen, wheelchairs, walkers, etc.)



Emergency room services



Skilled nursing care and health aide services for the homebound on a part-time or intermittent basis



Mental health care as an outpatient



A few prescription drugs administered by a doctor, like chemotherapy drugs

These are examples of the most significant items Part B will help you with. For a comprehensive list, go to Medicare.gov.

Costs

Premium

You'll pay a premium for Part B. The premium amount depends on your yearly income and can be automatically deducted from your Social Security benefits. For 2016, premiums range from \$104.90 to \$389.80 per month.

You may pay a penalty if you don't sign up for Part B when you are first eligible. Your cost for Part B may go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it. You'll pay that penalty for as long as you're enrolled in Part B.

This penalty may not apply to you if you are still working for an employer who provides group health coverage when you become eligible for Medicare.

Cost sharing

Deductible

Before Part B begins paying a share of your costs under Part B, you must first pay a deductible once a year. In 2016, your deductible is \$166 for the year.

Co-pay

Outpatient hospital services have co-pays for each service you get in an outpatient hospital setting.

Co-insurance

After you pay your deductible, Part B shares the cost of your care with you. Part B generally pays 80% and you pay 20% as co-insurance.

For more information about the details of Part B co-insurance, see page 16.

Enrollment

When can I join Part B?

As soon as you become eligible for Medicare, you can join Part B. Just sign up in your "initial enrollment period." ► Page 44

You can also join Part B later on, but only at certain times of the year, unless you qualify for an exception, such as working past age 65 and continuing to have coverage from your employer. ► Page 44

How do I sign up?

If you're receiving Social Security benefits when you turn 65 or otherwise become eligible for Medicare, you should automatically be enrolled in Parts A and B but check with your local Social Security office if you suspect there is a problem. If you don't want to join Part B, you can refuse Part B coverage by going to your local Social Security office.

If you're not receiving Social Security benefits, you can sign up for Part B at your local Social Security office.

Can Part B refuse to cover me or delay my coverage?

Assuming you are eligible for Medicare, you can't be refused Part B because of your medical history or a pre-existing illness. The time when your coverage begins depends on when you sign up. If you sign up promptly at the start of your initial enrollment period, your coverage will begin on the first day of the month you become eligible for Medicare.

How does renewal work?

Your Part B coverage renews automatically from year to year, so long as you pay the premium. You don't have to do anything.

Your share of Part B costs

In Part B, you'll pay a share of the cost of your care as you receive it. You'll pay the same share whether you need a little care or a lot.

What's my share?

You'll pay your share as a deductible, co-pays, and co-insurance. In 2016, your Part B deductible is \$166 per year. For co-insurance, in general, Part B pays 80% of the cost and you pay the remaining 20%. There are some exceptions to that rule, as are discussed below.

There are no limits on your out-of-pocket spending for cost sharing in Part B. If you have a chronic condition that requires a lot of care, or you have a serious illness, your cost-sharing amounts may be substantial.

How does this work?

Medicare covers thousands of specific medical procedures and decides how much it is willing to pay for each of them. The amount Part B will pay for any given procedure is called the "Medicare-approved amount." When you pay your share, the amount you are splitting with Part B is usually the Medicare-approved amount. In some cases, though, your share may be more than 20% of the Medicare-approved amount.

Accepting assignment

Most doctors agree to take Medicare's payment of the Medicare-approved amount as full payment. This is called "accepting assignment." If your doctor accepts assignment, your share is limited to 20% of the Medicare-approved amount.

Excess charges

Some doctors, though, do not agree to take the Medicare-approved amount as full payment. Medicare reduces the Medicare-approved amount for these doctors by 5%. Part B also allows these doctors to charge you up to an additional 15% of the reduced Medicare-approved amount. (This ceiling is less than 15% in some states, and some states prohibit additional charges completely.) This is called "balance billing" or "excess charges."

Co-insurance percentages

The cost-sharing percentage is not always 20%. For outpatient mental health services, for example, your 2016 co-insurance is 20%.

Co-pay amounts

Some cost sharing in Part B uses co-pays instead of co-insurance. In these cases, Medicare sets a dollar amount that you will pay.



What are "usual and customary" fees?

The "Medicare-approved" amount for a service is usually different from the amount a health care provider would charge a non-Medicare patient for the same service. That amount is often referred to as the provider's "usual and customary" fee. A provider's invoice may show the usual and customary fee, but that amount is not used to calculate the amounts either you or Medicare will pay.

Example: doctor who does accept assignment



Ellen visited a doctor who accepts assignment. Ellen has already paid her deductible for the year.

Interpret cardiovascular stress test	\$175
Read diagnostic X-ray	\$125
Doctor's usual and customary fee	\$300
Total Medicare-approved amount	\$220
Medicare pays 80% of approved amount	\$176
Ellen's 20% co-insurance	\$44
Total Ellen pays	\$44

Example: doctor who doesn't accept assignment



Ellen visited a doctor who doesn't accept assignment. Ellen has already satisfied her deductible.

Interpret cardiovascular stress test	\$175
Read diagnostic X-ray	\$125
Doctor's usual and customary fee	\$300
Total Medicare-approved amount	\$220
Reduced Medicare-approved amount (95% of Medicare-approved amount)	\$209
Medicare-approved amount + 15% of approved amount	\$240
Medicare pays 80% of reduced Medicare-approved amount	\$167
Ellen's 20% co-insurance	\$42
Ellen's 15% "excess charge"	\$31
Total Ellen pays (co-insurance + excess charges)	\$73

Note: Even though this doctor doesn't accept assignment, Medicare still limits the excess charges Ellen must pay to 15% of the Medicare-approved amount. The doctor receives \$240. This is less than the usual and customary fees of \$300 but more than the Medicare-approved amount.

Overview of Medicare Part C: Medicare Advantage

Big idea

Provide a single plan that combines help with hospital costs, doctor's visits and other medical services, plus prescription drug coverage if you want it

Description

Medicare Part C plans are usually referred to as “Medicare Advantage” plans. All Medicare Advantage plans are run by private companies, and they all combine coverage for hospital stays with coverage for doctor visits. You can choose a plan that includes prescription drug coverage, often at no additional premium, or you can choose a plan without prescription drug coverage.

To learn more about specific kinds of Medicare Advantage plans see pages 22–29.

What providers can I see?

The terms of these plans vary. In some plans, your health care is “coordinated.” That means the plan coordinates your coverage through a primary care physician who manages the care you receive from specialists and hospitals. You may have to choose specific doctors and hospitals.

In other plans, you can get care from any Medicare-eligible provider who accepts the terms, conditions and payment rates of the plan before providing coverage. Doctors and hospitals can decide whether or not to accept those terms, conditions and payment rates each time they furnish covered services.

All Medicare Advantage plans have “service areas.” These are areas, typically a county, state or region, where they offer coverage. Generally, you must live in a plan's service area in order to join it. However, all Medicare Advantage plans must offer nationwide coverage for emergency care, urgent care (care provided outside a doctor's office or emergency room for conditions that require immediate attention) and renal dialysis.

Coverage limits

The terms of these plans vary. Look at the plan details to see limits or exclusions it might have.

What won't I get help with?

Medicare Advantage plans must cover the same services as Medicare Parts A and B, except they don't provide hospice care, which is still covered by Original Medicare. You can keep your Medicare Advantage plan and receive hospice at the same time. Your Medicare Advantage plan covers your health benefits not related to your hospice care. Look at the plan details to see what other exclusions from coverage it might have. Plans that include drug coverage may have restrictions related to that coverage. ▶ Page 30

Costs

Premium

If you join a Medicare Advantage plan, you will continue to pay your Part B premium and your Part A premium, if you have one. The plan may also charge its own premium, although some Medicare Advantage plans do not. Premiums for Medicare Advantage plans can vary widely.

Insurers can change premiums and other terms of the plan from year to year. In the fall, insurers announce next year's premiums and other terms of their plans.

Cost sharing

Deductible

Some plans charge deductibles, and some don't. Look at the plan for details.

Co-pay

Many plans charge co-pays. Look at the plan for details.

Co-insurance

Medicare Advantage plans set their own terms about co-insurance. Look at the plan for details.

Maximum out-of-pocket limits

All Medicare Advantage plans protect you from high cost sharing by limiting the amount you will have to spend each year. Part A and Part B don't have this feature.

What will I get help with?

All the benefits of Part A, except hospice care



Hospital stays



Skilled nursing



Home health care

All the benefits of Part B



Doctor visits



Outpatient care



Screenings and shots

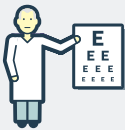


Lab tests

Prescription drug coverage is included in many Medicare Advantage plans, but not all.



Extras may be bundled with the plan.



Eye care



Hearing care



Wellness services



Nurse helpline

These are examples of the most significant items Part C will help you with. For a comprehensive list, see the plan's specific benefits.

Coverage gap

If your plan has Medicare Part D, see page 31 to learn about Medicare Part D cost sharing.

Enrollment

When can I join a Medicare Advantage plan?

As soon as you become eligible for Medicare, you can join a Medicare Advantage plan. You must also join Parts A and B. Just sign up in your “initial enrollment period.” ▶ Page 44

You can join later, but only at certain times of the year, unless you qualify for an exception. ▶ Page 44

How do I sign up?

Each private company that offers a Medicare Advantage plan handles the enrollment in its plan. To join, you'll need to contact the company and ask how to join.

Can Medicare Advantage plans refuse to cover me or delay my coverage?

Assuming you have joined Parts A and B, you can't be refused by any plans in your area that are accepting new members. Some Special Needs Plans have special eligibility rules that you must satisfy to join the plan. And special rules apply to people with end-stage renal disease. The time when your coverage begins depends on when you sign up.

Can I change my coverage later?

You have the chance to change your coverage each year. ▶ Page 45

How does renewal work?

Your plan renews automatically from year to year, so long as you pay the premium and the plan is still available in your service area. You don't have to do anything.

Your share of Part C costs

In Medicare Advantage plans, the company that offers the plan sets the premium and decides on the cost sharing. You'll need to look at the details of each plan you're considering.

What's my share?

Most Medicare Advantage plans use a combination of deductibles, co-insurance and co-pays to share the costs with you. These cost-sharing arrangements will usually apply to all of the services the plan covers — hospital stays, doctor's visits, drug coverage if you have it, and so on.

How does this work?

You will need to investigate the details of a plan to get the full story on its cost sharing. Plans vary widely, and their cost-sharing usually works quite differently from the cost sharing used in Medicare Parts A and B.

For example, in Part A, your cost sharing for a five-day hospital stay would be your \$1,288 (2016) deductible. In a Medicare Advantage plan, you might pay a \$150 per day co-pay for each day in the hospital. This is just an example, and each plan may vary.

Out-of-pocket limits

Limits on your cost sharing are another way Medicare Advantage plans may differ from Part A and Part B.

In Part A and Part B, there are no limits on your out-of-pocket spending for cost sharing. And in some situations, like extremely long hospital stays, your coverage under Part A ends entirely, and you become responsible for paying all of your own costs.

In contrast, all Medicare Advantage plans offer a feature that caps your out-of-pocket spending for cost sharing like co-pays and deductibles in any given year. The out-of-pocket maximum will vary by plan, but the highest out-of-pocket maximum for in-network services in 2016 is \$6,700.

Drug cost sharing

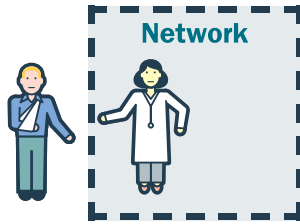
Cost sharing for drug coverage that is built into Medicare Advantage plans generally works in ways that are similar to cost sharing in stand-alone Medicare Part D plans. ► Page 31



Tip

These costs vary from plan to plan. Shop around for a plan that best fits your needs.

Example: coordinated care in-network office visit



Michael has a coordinated care Health Maintenance Organization (HMO) plan. He visits an in-network doctor.

Office visit	\$100
Co-pay for office visit	\$10
Total Michael pays	\$10

Example: brief hospital stays



Maria stays in the hospital three days, goes home for a week and then spends four more days in the hospital. Her coordinated care plan has a \$150 co-pay for each day of a hospital stay.

Days 1 to 3 co-pays for first stay	\$450
Days 1 to 4 co-pays for second stay	\$600
Total Maria pays	\$1,050

Example: long hospital stay



William stays in the hospital 185 days. His coordinated care plan applies a \$150 per day co-pay for each day of a hospital stay and puts a \$3,000 maximum, or cap, on out-of-pocket spending.

Days 0 to 20 (20 days at \$150 per day)	\$3,000
Days 21 to 185 (after the cap is reached)	\$0
Total William pays	\$3,000

Different flavors of Medicare Advantage plans

Congress added Medicare Advantage plans to give Medicare participants more choices about how they receive their health care. That's why you'll find different kinds of plans in this category.

Medicare Advantage plans are all offered by private companies that have been approved by Medicare. To encourage competition, Medicare gives the private companies flexibility in setting the terms of each plan. That means you'll find considerable variation among plans as you shop.

Medicare Advantage includes several kinds of plans.

Health Maintenance Organization (HMO) Plans ▶ Page 23

Point of Service (POS) Plans ▶ Page 23

Preferred Provider Organization (PPO) Plans ▶ Page 23

Special Needs Plans (SNP) ▶ Page 24

Coordinated Care Plans

Private Fee-For-Service (PFFS) Plans ▶ Page 26

Medical Savings Account (MSA) Plans ▶ Page 27

Other Plans

In four kinds of Medicare Advantage plans — HMO, POS, PPO and Special Needs Plans — your care is “coordinated.” That means the plan may coordinate your coverage through a primary care physician who manages the care you receive from specialists and hospitals. You may have to choose specific doctors and hospitals. This is different from Medicare Part A and Part B, where you can visit any doctor or hospital that

accepts payment from Medicare. The other two types of plans — Private Fee-For-Service (PFFS) plans and Medical Savings Account (MSA) plans — do not use coordinated care. In these plans, you can get care from any provider who is willing to accept the terms, conditions and payment rates each time they furnish covered services for you.

Choosing a plan

Many people who choose a Medicare Advantage plan choose a coordinated care plan — an HMO, POS, PPO or Special Needs Plan. If you're interested in a Medicare Advantage plan, you'll need to do some homework.

Look at the monthly premium (if any) you'll pay to join. Then estimate your total cost sharing for services. Find a Medicare Advantage plan where the cap, or maximum on your out-of-pocket spending, fits your budget. Consider whether a plan's network (if it has one) gives you access to the doctors you want to see.

If you want both prescription drug coverage and a coordinated care Medicare Advantage plan like an HMO, POS or PPO plan, choose one with prescription drug coverage built in. You can't combine a stand-alone prescription drug plan with a coordinated care Medicare Advantage plan. You can, however, combine a stand-alone prescription drug plan with a PFFS or MSA plan.

Shopping for a Medicare Advantage plan

Start shopping by finding out what's available in your area. You can find a list of plans at **Medicare.gov**, or by calling the Medicare Helpline. Medicare's list of plans includes contact information for each plan. You can call each plan and ask for more information.

▶ Page 58

You can also get plan information from your State Health Insurance Assistance Program (SHIP).

▶ Pages 56–57

If you have end-stage renal disease, there are some special rules for you. Contact the Medicare Helpline, your state Medical Assistance program or the American Kidney Fund (AKF) for more information.

▶ Page 58

Coordinated care plans: HMOs, POS and PPOs

Medicare Advantage coordinated care plans (HMOs, POS and PPOs) offer one-stop shopping for all of your health care. They combine hospital care and doctor's visits and other outpatient care in a single plan. Many plans offer prescription drug coverage, too.

These plans are run by private companies. They're called coordinated care plans because they are built on the idea of a network of doctors and hospitals working together to provide care. Each plan creates its own network.

How are these plans different from Medicare Part A and Part B?

These plans usually take a broader view of your care than Parts A and B do. Coordinated care plans cover all of the care covered by A and B (except for hospice care, for which you can still receive coverage under Medicare Part A), but they also often include additional benefits designed to help you stay healthy. Some plans offer nurse helplines and other resources that can help you take a more active role in your health care.

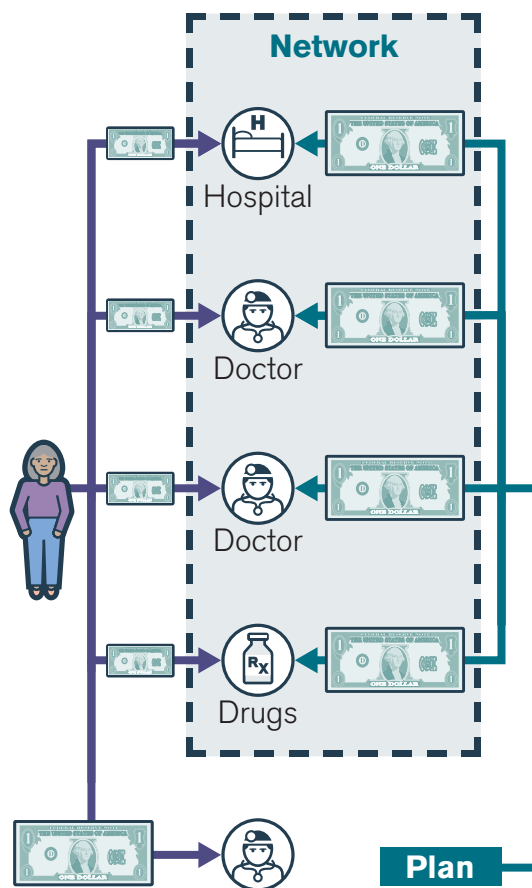
Plan networks also work to improve the quality of care through management techniques for the providers in the network.

Unlike Part A and Part B, these plans may have some limits on your choice of doctors and hospitals. The limits depend on the type of plan.

In an HMO-type plan you must use doctors who belong to the plan, or go to hospitals in the network, for your care. If you go outside the network for care, other than emergency care, urgent care or renal dialysis, you must pay for your own care. These plans may require you to choose a primary care physician. This doctor may then manage any care you receive from specialists. In some plans, you may need a referral from this physician to see a specialist.

A POS plan is a type of HMO plan that allows members the ability to visit doctors and hospitals outside their network for some covered services, usually for a higher co-payment or co-insurance. Some POS plans do not require referrals for specialty services.

In a PPO-type plan, you are likely to have more freedom to choose your doctor. These plans typically don't require you to have a referral to see a specialist. And you can see doctors outside the network without having to pay the entire cost yourself. If you do visit a doctor or hospital outside the network, though, you'll usually pay a larger share of the cost of your care.



You pay all or a larger part of the cost of services outside network.

Plan pays a bigger share for services inside network.

Coordinated care plans offer a network of health care providers. You'll usually pay more if you use providers outside the network, but sometimes you'll pay the entire cost.

Coordinated care plans: Special Needs Plans

Medicare Advantage Special Needs Plans are care management plans, a special type of coordinated care plan designed for people with special needs. They combine hospital care and doctor's visits and other outpatient care in a single plan.

Because people who qualify for Special Needs Plans often need a considerable amount of medical care, these plans usually focus on helping members receive well-coordinated care. Some offer care managers or nurse practitioners who act as advocates to help members get the care they need when they need it.

How are these plans different from Medicare Part A and Part B?

Special Needs Plans may serve people in any of these groups:

- People who are institutionalized in a nursing home or other long-term care facility because they are unable to care for themselves
- People who are eligible for both Medicare and the Medicaid assistance program (sometimes called "dual eligibles")
- People with certain chronic diseases, such as diabetes or heart disease

Some Special Needs Plans only serve people who are eligible for one of the three types of plans. Other plans serve people who are both institutionalized and eligible for Medicaid.

These plans are run by private companies. They use a network of doctors and hospitals working together to provide care. Each plan creates its own network.

Choosing a plan

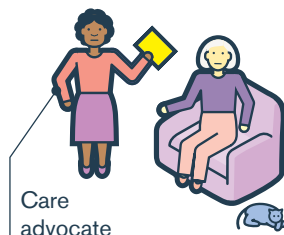
If you are interested in a Special Needs Plan, contact the plan to learn more about who's eligible. Some plans may have eligibility requirements beyond just being eligible for Medicare. For example, you might need to qualify for Medicaid to join some plans. You can join a Special Needs Plan at any time during the year as long as you're eligible.

Like other Medicare Advantage plans, details of items like premiums and cost sharing vary from plan to plan. Pay careful attention to the details of the plan before you choose.

Example of Special Needs Plans at work

By giving you extra support with complex health needs, these plans can help you stay healthier while lowering overall costs. Here's an example of how one Special Needs Plan manages care.

1



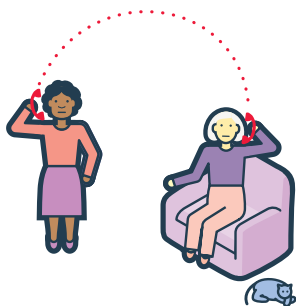
Specially trained care advocate evaluates individual's health and living conditions and defines customized plan of care.

2



Primary care team is assigned to coordinate medical care and may assist member to access social services like legal aid and heating assistance.

3



Telephone check-ins and visits help care advocate identify new problems early and intervene if necessary. Plan of care can be altered, or members of the primary care team can be consulted.

4



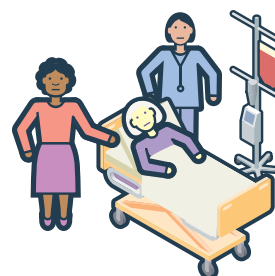
Care advocate teaches people who have routine contact with the individual to be alert for signs of trouble. Family members and other caregivers can recognize subtle clues that may signal illness or change to a chronic condition.

5



When an individual requires more support than is available at home, she can move to an appropriate care facility. Care advocate helps ensure there are no disruptions to the individual's care.

6



When hospitalizations are necessary, the care advocate works to maintain continuity of care and helps ensure that the individual's stay is no longer than necessary.

Private Fee-For-Service plans

Medicare Advantage Private Fee-For-Service (PFFS) plans are different than HMO, PPO or Medicare supplement plans.

How are these plans different from Medicare Part A and Part B?

One major difference between Private Fee-For-Service plans and Medicare Parts A and B is that enrollees join a plan run by a private company. Enrollees of these plans typically visit any Medicare-eligible provider who is willing to accept the plan's payment terms and conditions. It is important to confirm that the provider accepts payment from a specific Private Fee-For-Service plan each time services are provided. Doctors or hospitals are not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you. Some providers do not accept Private Fee-For-Service plans, or accept only certain Private Fee-For-Service plans. You can receive services throughout the United States.

Some of these plans do not offer prescription drug coverage. If you choose one of these plans and want drug coverage, you'll need to buy a stand-alone Medicare Part D prescription drug plan.

Many of these plans offer a broader choice of covered services than Parts A and B. Some cover additional services, like routine vision exams.

Choosing a plan

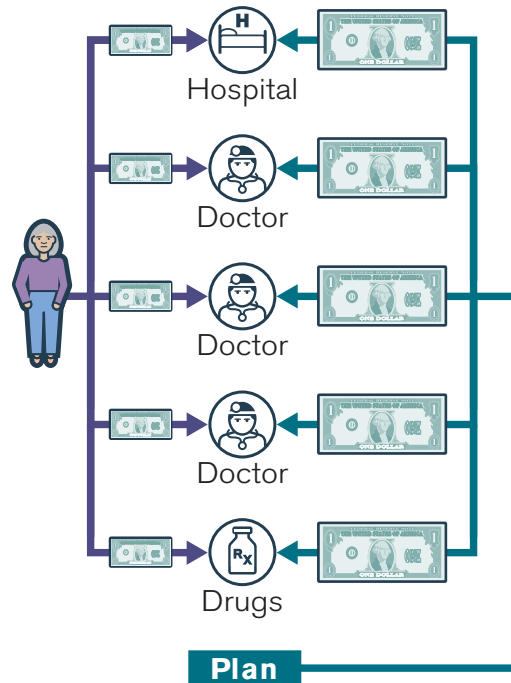
Medicare Advantage Private Fee-For-Service plans have much of the same flexibility in setting premiums, cost sharing and other terms as Medicare Advantage coordinated care plans. Just as coordinated care plans vary considerably, the details of Private Fee-For-Service plans can as well.

Pay careful attention to the details of the plan. You may find a wide variation in your estimated out-of-pocket costs from plan to plan, or compared with Medicare Part A and Part B.

Choosing a provider

You should confirm that a doctor, hospital or other care provider is Medicare-eligible before receiving services. When choosing a provider, you should also look for one who accepts the terms, conditions and payment rates from the plan before providing service for you. If you don't, you may be responsible for any difference between the plan's payment amount and the provider's total charges. In some cases, you could be responsible for paying all of the charges.

The flexibility of a Private Fee-For-Service plan also means that important features of a plan, like premiums and deductibles, can change from year to year. You'll need to monitor changes in the plan to make sure that it's still the best choice for you.



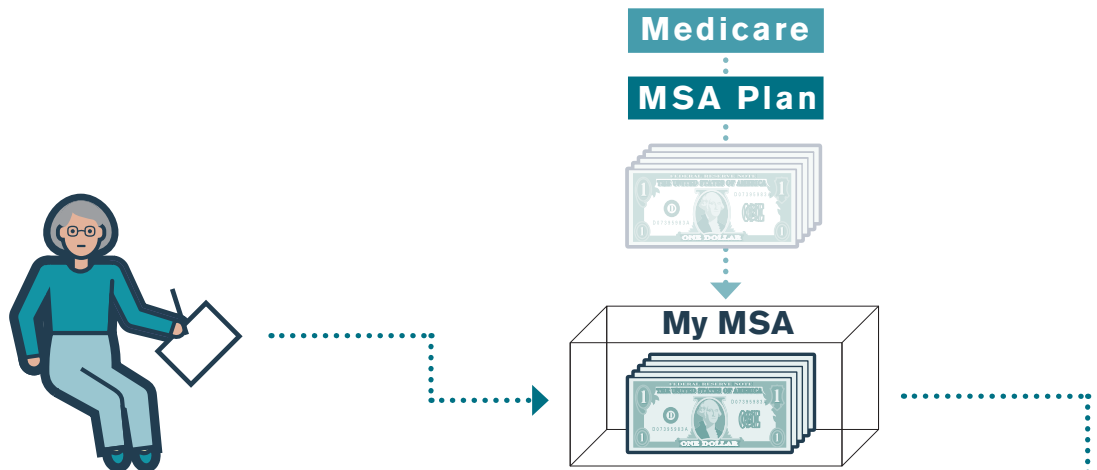
Plan pays most of the cost of services, and you pay a share.

Private Fee-For-Service plans allow you to use any provider who is willing to accept terms, conditions and payment rates from the plan.

Medical Savings Account plans

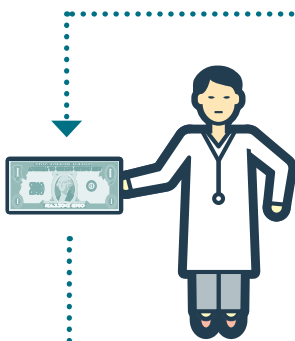
Medical Savings Account plans

A Medical Savings Account (MSA) plan is a type of Medicare Advantage plan that combines coverage for Medicare Part A and Part B services with a special savings account fund you can use to pay for covered expenses tax-free. Once you have paid a deductible, the plan covers your Medicare-covered expenses. MSAs are available almost everywhere. Like other Medicare Advantage plans, terms vary from plan to plan.



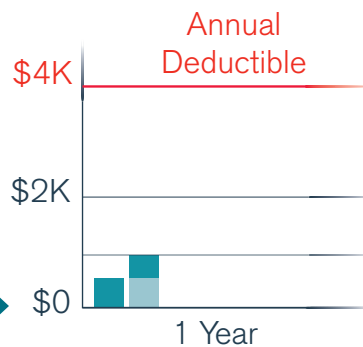
1 You enroll in an MSA plan. You set up a special account with a bank selected by the plan. You pay your monthly Part B premiums to Medicare. But you will not pay a monthly plan premium.

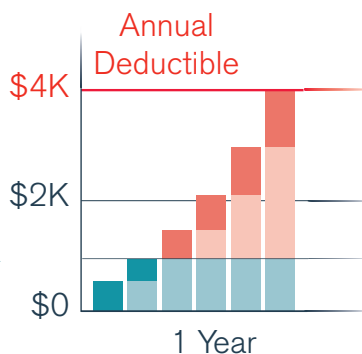
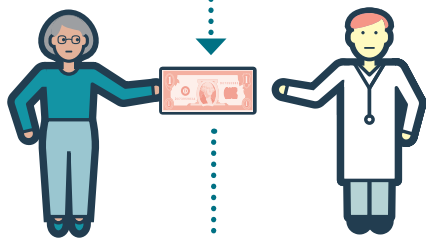
2 Medicare gives your plan a certain amount of money. The plan deposits that money into your MSA. In most plans, funds in the account earn interest tax-free.



3 You can use the account funds tax-free to pay for any health care services that qualify under IRS rules. Qualified services include some services that aren't covered by Medicare.

4 Amounts you pay for health care services covered by Medicare Part A or Part B count toward your annual deductible. Let's say \$4,000.

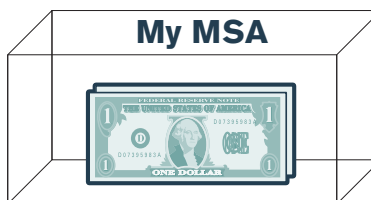
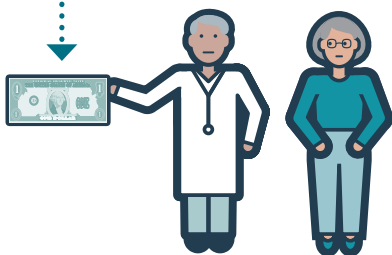




5 If you use all the money in your MSA, you pay additional health care costs out of your own pocket until you reach your annual deductible.

6 Every Medicare-covered health care expense counts toward your annual deductible.

MSA Plan



7 After you reach your deductible, your plan pays 100% of Medicare-covered services. Read the details of your plan to learn more about the plan's cost sharing and out-of-pocket costs.

8 Money left in your MSA at the end of the year carries over to the next year. At the start of a new year, a new allowance is deposited into your MSA. Funds accumulate tax-free.

■ You pay
 ■ You paid
 ■ Insurance pays
 ■ Insurance paid

Key



Tip

Medicare Part D prescription drug benefits are not included with MSA plans, so you'll have to join a stand-alone Medicare Part D plan if you want help with prescription drug costs.

Overview of Medicare Part D

Big idea

Provide help with the cost of prescription drugs

Description

Medicare Part D helps pay for the prescription drugs you use. Medicare Part D coverage is not automatic. You decide whether to enroll in a Medicare Part D plan. If you delay signing up after you are eligible, though, you may pay a penalty on your premium, unless you qualify for an exception.

Prescription drug coverage is an insurance policy you buy from private companies. You can buy a separate policy just for drugs, called a prescription drug plan (PDP). Or you can buy some types of Medicare Advantage plans that include drug coverage.

The federal government has created guidelines for the types of drugs that must be covered by drug plans and set minimum standards of benefits. Insurance companies that offer Medicare Part D plans must meet these standards. But all plans are not the same. They vary by cost and by their formulary, or list of specific drugs covered. ▶ Pages 34–35

What pharmacies may I use?

Each drug plan decides which pharmacies plan members may use. Plans may also limit your choice of pharmacies by geographic area, such as a state. Other plans offer nationwide coverage. If you travel often, you may want to consider a plan that allows you to access pharmacies wherever you go. Some plans also offer mail order services, so you can have drugs mailed to your home. Some plans may also offer a subset of pharmacies known as a “preferred” network with even lower costs.

Each Medicare Part D plan has a service area, or area where it operates. You must live in a plan’s service area to join it.

Coverage limits

Medicare Part D coverage has different levels of cost sharing until you have spent \$4,850 (2016) out-of-pocket in a single year for drugs that are covered by the plan. ▶ Page 34

Your True Out-of-Pocket (TrOOP) costs include the amount you pay or others pay on your behalf toward the cost of your prescription drugs, including deductible, co-pays, co-insurance and payments made in the coverage gap. Premiums do not count toward True Out-of-Pocket costs.

Once you have passed this spending cap, you are eligible for what Medicare Part D calls “catastrophic coverage.” You pay only a small co-insurance or co-pay for a covered drug and your plan pays the rest for the remainder of the year. The terms of these plans vary. Look at the details of the plan to see limits on coverage.

What won’t I get help with?

Plans vary in which specific drugs they cover, and you won’t get help with the cost of a drug that is not covered by a plan. For example, a plan may cover only certain cholesterol-reducing drugs. If the specific cholesterol-reducing drug you take isn’t covered by a plan, the plan won’t help you with the cost of that drug. ▶ Page 34

The federal government also requires plans to exclude certain types of drugs from the plan entirely. Weight-loss drugs are one example. Some plans, called enhanced plans, do cover some of these types of drugs.

In most plans, there is a stage of cost sharing called the “coverage gap,” or the “donut hole.” In this stage you must pay most of the plan’s price for the medications you take. ▶ Page 32

What will I get help with?

Prescription drugs.



Tip

If you choose Medicare Part D coverage, always fill prescriptions at a participating network pharmacy and show your member plan ID card. You’ll have an accurate record of your total spending for drugs, and you’ll get the plan’s price for your drugs. That is especially important if you enter the coverage gap.



Costs

Premium

The insurance companies that offer Medicare Part D drug plans (and Medicare Advantage plans with drug coverage) set their own prices. Monthly premiums for drug plans can vary widely, even for similar coverage.

Each year in October, the insurance companies announce premiums and other details of their plans for the coming year.

Unless you qualify for an exception, you may pay a penalty on your premium if you don't sign up for Medicare Part D coverage as soon as you are eligible. This penalty is set by Medicare. For each month you delay, you may pay an additional 1% (of the average premium) per month. You will pay that penalty for as long as you're enrolled in Medicare Part D. For more information, see page 44.

Cost sharing

Deductible

Some plans charge a deductible and some don't.

Co-pay

Some drug plans charge a co-pay each time you fill a prescription.

Co-insurance

Some drug plans charge a percentage of the cost when you fill a prescription.

Coverage gap

In 2016, you pay no more than 58% of the total cost for generic drugs or 45% of the total cost for brand name drugs. You will continue to receive additional savings in the upcoming years until the coverage gap is closed in 2020. To learn more about Medicare Part D cost sharing see page 32.

Enrollment

When can I join a drug plan?

If you are entitled to Part A or enrolled in Part B, you cannot be refused enrollment in a prescription drug plan as soon as you become eligible for Medicare. Just sign up for a drug plan in your initial enrollment

period. You can join later, but only at certain times of the year, unless you qualify for an exception, like moving to an area where your plan is not available.

► Page 44

How do I sign up?

Each private company that offers a drug plan handles the enrollment in its plan. To join, contact the company and ask how to become a member. You can also join online at the Medicare website **Medicare.gov**.

Can Medicare Part D refuse to cover me or delay coverage?

If you are entitled to Part A or enrolled in Part B, you cannot be refused enrollment in a prescription drug plan. You can only join one plan at a time, either a stand-alone drug plan or a Medicare Advantage plan that includes drug coverage.

Can I change plans later?

You can change your Medicare Part D plan each year during the Medicare Open Enrollment Period from October 15 to December 7 unless you qualify for an exception. Coverage becomes effective starting January 1 of the following year.

How does renewal work?

Your Medicare Part D coverage renews automatically from year to year, unless you choose to change plans during the Medicare Open Enrollment Period.

What's my share?

In Medicare Part D, you'll pay a share of the cost of the medications you take. Each plan that provides drug coverage, whether it's a stand-alone plan or a Medicare Advantage plan with drug coverage built in, will include cost sharing.

Each plan that provides drug coverage will share costs a differently. Look at the details of the plan you're interested in to see how its cost sharing works. See the next page for an example of how cost sharing and the coverage gap, or "donut hole," works.

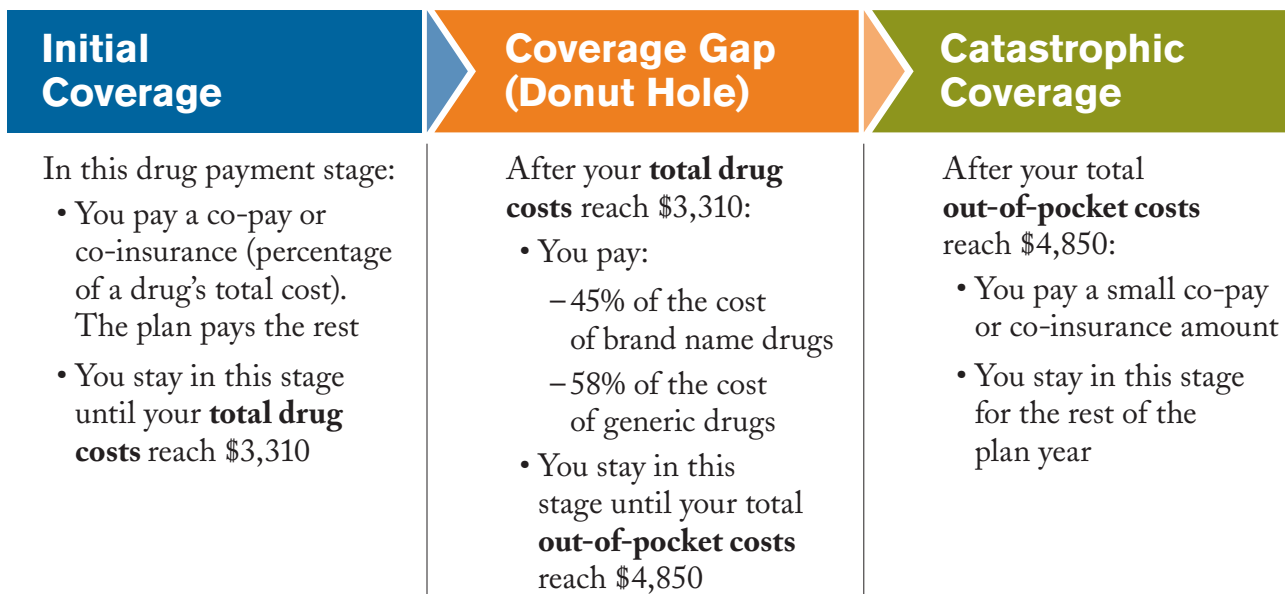
Your share of Medicare Part D costs

How does this work?

In Medicare Part D, there is no Medicare-approved price. Each company negotiates its own prices with pharmacies and drug manufacturers. Your co-pays and co-insurance are calculated using the plan's price for the drug and guidelines set by Medicare. The price you pay is usually discounted because you're part of a big group purchase. Prescription drug coverage also typically uses cost sharing in which you must pay the plan's total drug price.

Annual deductible

If your plan has a deductible, you pay the total cost of your drugs until you reach the deductible amount set by your plan. Then you move to the initial coverage stage.



Total Drug Costs: The amount you pay (or others pay on your behalf) and the plan pay for prescription drugs starting January 2016. This does not include premiums.

Out-of-Pocket Costs: The amount you pay (or others pay on your behalf) for prescription drugs starting January 2016. This does not include premiums.

Over the next several years, Part D benefits will increase so Medicare members will pay less for covered drugs while in the coverage gap. By 2020, the coverage gap will close and Medicare members will pay only 25% for covered brand name and generic drugs from the time they meet the deductible (if applicable) until they reach the out-of-pocket limit.

Your plan may provide different coverage. See your Summary of Benefits or Evidence of Coverage for the actual amount you pay in each stage.

Amounts listed reflect the 2016 plan year.

The coverage cycle starts over each year on January 1.

Medicare sets the rules about which payments count toward your out-of-pocket and total drug costs.



Example: heavy prescription drug spending

Enrico, age 66, has several chronic conditions. Without coverage he spends more than \$950 a month on drugs. He has Original Medicare (Medicare Part A and Part B), plus a stand-alone Medicare Part D drug plan with a \$384 annual premium. Because his drug costs are high, he reaches Stage 3, catastrophic coverage.

Total annual drug costs without a Medicare Part D drug plan (\$950 per month x 12 months)	\$11,400
Annual premium for Part D drug plan (\$32 per month x 12 months)	\$384
Stage 1 – Initial coverage (Enrico’s share during this stage)	\$720
Stage 2 – Coverage gap (his additional cost sharing up to the limit)	\$4,130
Stage 3 – Catastrophic coverage (his share during this stage)	\$236
Total Enrico pays out-of-pocket for the year	\$5,470
Total annual savings with Medicare Part D plan	\$5,930

Example: moderate prescription drug spending

Helen, age 65, spends \$100 a month for two drugs. She joins a Medicare Advantage plan with built-in drug coverage. There’s no additional premium for drug coverage. Because her spending is fairly low, she only reaches Stage 1, initial coverage. She still saves money with the plan.

Total annual drug costs without a Medicare Part D drug plan (\$100 per month x 12 months)	\$1,200
Annual premium for drug coverage with Medicare Advantage plan (\$32 per month x 12 months)	\$384
Stage 1 – Initial coverage (Helen’s share during this stage)	\$250
Stage 2 – Coverage gap	N/A
Stage 3 – Catastrophic coverage	N/A
Total Helen pays out-of-pocket for the year	\$634
Total annual savings with Medicare Part D plan	\$566



Tip

This is one example of Medicare Part D savings. Many people see additional savings because their plans get discount prices. Make sure you read the details to understand what you will pay.

Getting the most from a Medicare Part D plan

You can find a Medicare Part D plan that's right for you if you shop carefully. It's easy to focus only on your premium amount, but there are other things to look at when you choose a plan. For example, you should also look at your estimated out-of-pocket spending. That depends on the plan's cost sharing (deductibles, co-pays and co-insurance) and the plan's prices for the drugs you take.

Also consider whether the plan offers a mail order option, which can reduce your co-pay costs and make it more convenient to get your drugs. And if the plan offers a preferred pharmacy network, be sure to compare those costs versus other in-network pharmacies to determine whether switching pharmacies might save a considerable amount.

You should also check the plan's formulary to see if it covers the drugs you take. What's a formulary? It's a list of the drugs that a plan covers. Each Medicare Part D plan has its own formulary.

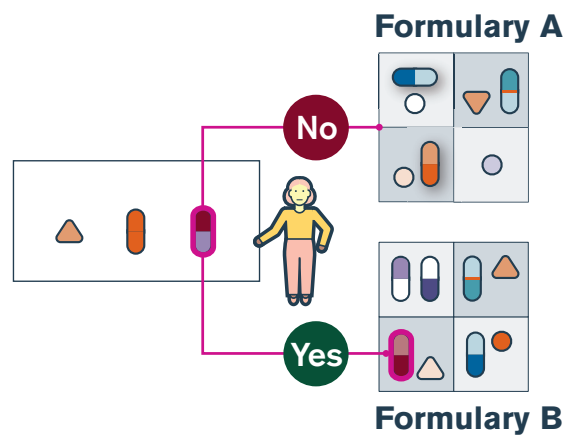
FDA-approved drugs



All FDA-approved drugs are grouped by what the drugs do — fight infection, lower blood pressure, etc. Drugs in the same group treat the same condition.






Plans build their specific formularies by selecting drugs from these groups.

Before you choose a plan, look at the plan's formulary to see if it covers the drugs you take. If it doesn't, another plan that does cover the drugs is probably a better fit.



Tiered formulary

Many drug plans have what’s called a “tiered formulary.” That means the plan has divided drugs in its formulary into groups. Some groups will cost you more money than others. For example, a generic version of a drug may have a lower co-pay than a brand-name version of the same drug.

Formulary	Tiered Formulary
 Tier 5 (\$\$\$\$\$)
 Tier 4 (\$\$\$\$\$)
 Tier 3 (\$\$\$)
 Tier 2 (\$\$)
 Tier 1 (\$)

Step therapy

Some plans with tiered formularies have special requirements for certain drugs. One of these requirements is called “step therapy.” With step therapy, you must first try a less-expensive drug to see if it works for you. You may “step up” to a more expensive drug that treats the same condition only if you and your doctor can show that the less-expensive drug didn’t work for you.

What if my drugs aren’t on the formulary?

Sometimes you can’t find a plan that includes all of your drugs. Or your plan may change its formulary to exclude one of your drugs. A plan can change its formulary after giving you notice. But a change that excludes a drug you are already taking usually will not affect you until the next year.

When your drugs aren’t on the formulary, talk to your doctor. There may be another drug on the formulary similar to your current drug. Or your doctor may be able to ask your plan to make an exception for you. Your doctor will need to show proof that no drug on the formulary works for you.

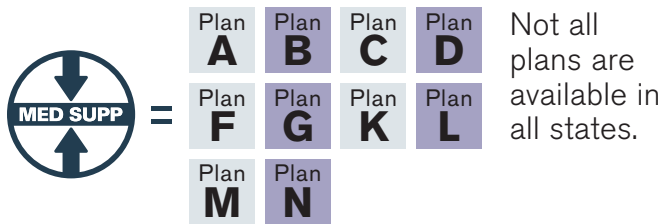
Overview of Medicare supplement (Medigap) insurance

Big idea

Provide private insurance coverage that helps fill the gaps in Medicare Parts A and B

Description

To help pay the costs that Parts A and B don't cover, many people purchase Medicare supplement policies, or "Medigap" policies. These policies cover some or all of the expenses that Medicare Parts A and B do not cover. Ten standard plans are available, labeled "A" through "N."



Medicare supplement policies aren't a government benefit, like Parts A and B. They are insurance policies sold by private companies. Whether you buy a policy is up to you.

For more information about the gaps each standard plan fills, see page 38.

Coverage limits

All Medicare supplement policies provide an additional 365 days of hospital care during your lifetime, beyond your Medicare lifetime reserve. No Medicare supplement policy covers days in a skilled nursing facility beyond the 100 days Part A pays for. As a rule, there are no geographic limits on where you receive the care covered by your Medicare supplement policy, as long as the care is received in the United States. Some policies do offer coverage of some emergency care outside the United States.

What won't I get help with?

In general, a Medicare supplement policy only helps you with your cost sharing for Parts A and B, like deductibles, co-pays and co-insurance. They don't cover long-term care (like nursing home care), routine vision, dental or hearing care, hearing aids, eye glasses, or private-duty nursing.

What will I get help with?



Part A deductibles



Part B deductibles



Co-insurance and providers' excess charges



Cost of blood transfusions



Cost of additional hospital days after you've used up your Part A benefits



Hospital and skilled nursing facility



Some preventive care benefits



Foreign emergency medical benefits



Some drugs the provider must give you



Costs

Premium

As a general rule, the more generous the coverage, the higher the premium. Even for exactly the same coverage, however, premiums for Medicare supplement policies can vary widely from insurer to insurer.

Your Medicare supplement premiums may also rise over time, after you've bought the policy.

Cost sharing

Deductible

Some companies offer high-deductible versions of plan F. With these plans, you'll pay the plan's deductible first, before the plan begins covering any of your expenses. Plans C and F pay the Medicare Part B deductible.

Co-pays

Plan N requires Part B co-pays to cover office visits and trips to the emergency room.

Co-insurance

Plans K and L use co-insurance to split costs between you and the insurance company until you reach your out-of-pocket limit.

Enrollment

When can I buy a Medicare supplement policy?

You can apply to buy a Medicare supplement policy at any time after you reach age 65 and join Medicare Part B.

Medicare guarantees you the right to buy any Medicare supplement policy available where you live during the six months after you turn 65 and enroll in Medicare Part B. This six-month period is called your open enrollment period. During this time, the insurer can't consider your medical history or current health in setting the premium. The insurer may be able to make you wait for six months before coverage begins for an illness you have (called a pre-existing condition) when you buy the plan.

How do I sign up?

Each private company that offers Medicare supplement policies handles its own enrollment. To join, you'll need to contact the company and ask how to join.

Can Medicare supplement insurers refuse to cover me or delay my coverage?

After your open enrollment period ends, insurers can refuse coverage or charge you a higher premium based on your health, or make you wait to get coverage for an illness you currently have. There are certain limited situations in which you have the right to buy a policy regardless of your health, after your open enrollment period ends.

Can I change my coverage later?

You can drop a Medicare supplement policy and apply for another whenever you like. But you are buying a new policy and you can be charged a higher premium or refused entirely. There are certain limited situations in which you have the right to buy a policy regardless of your health after your open enrollment period ends.

How does renewal work?

Medicare supplement policies must be "guaranteed renewable." That means the policy must be renewed automatically from year to year, so long as you pay the premium on time.

What Medicare supplement plans cover

The federal government has 10 different Medicare supplement plans, named with letters from “A” to “N.” (These letters have no relationship to the Medicare Part A, B, C and D designations.) The different types vary in which gaps in coverage they fill. To keep it simple, all policies with the same letter offer the same

benefits. This chart shows standard benefits for each plan type. Not all plans are available in all states. The plans in Massachusetts, Minnesota and Wisconsin differ from those shown below. Call your state insurance department for descriptions of these plans.

10 Standard Medicare Supplement Plans

Benefits Covered	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Part A hospital co-insurance and 365 extra hospital days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%**	75%**	50%	100%
Part B co-insurance or co-pays	100%	100%	100%	100%	100%	100%	50%**	75%**	100%	100% except certain co-pays***
Part B annual deductible			100%		100%					
Part B excess charges					100%	100%				
Cost of blood transfusion (first three pints)	100%	100%	100%	100%	100%	100%	50%**	75%**	100%	100%
Cost of foreign travel emergency (up to the plan limits)			80%	80%	80%	80%			80%	80%
Hospice care co-insurance cost	100%	100%	100%	100%	100%	100%	50%**	75%**	100%	100%
Part B preventive care co-insurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Skilled nursing facility care co-insurance			100%	100%	100%	100%	50%**	75%**	100%	100%
Yearly out-of-pocket limit (2016)	No limit	No limit	No limit	No limit	No limit	No limit	\$4,960	\$2,480	No limit	No limit

Note: *Plan F also comes in a high-deductible version, under which you must pay for Medicare-covered costs up to the deductible amount of \$2,180 in 2016 before your Medigap plan pays anything.

**100% after you reach your yearly out-of-pocket limit.

***\$20 co-pay for doctor visit and \$50 co-pay for ER visit.

How Medicare supplement insurance policies work



Shopping for a Medicare supplement policy

It can pay to shop around for a Medicare supplement policy. Even though the federal government defines standard benefits for the plans, prices vary among companies. You may find that two companies charge very different prices, or premiums, for identical coverage.

Several factors can affect your premium. First, prices reflect marketplace conditions. As health care costs in your state rise, you may see increases in your Medicare supplement premium.

Second, Medicare supplement insurers use several different methods of pricing their policies. This is called “rating.” Different rating methods can affect your premium, too.

To find out what plans are available to you, visit the Medicare website. Or you can call your state’s State Health Insurance Assistance Program (SHIP) to get a list of plans offered in your state. This program can also give you free counseling about choosing a Medicare supplement policy.

Medicare supplement policies are private insurance, and the companies that offer them are regulated by the state you live in. You can call the State Insurance Department in your state to find out more about a company that offers Medicare supplement policies in your state.

How Medicare supplement policies work

Different plans of Medicare supplement policies cover different types of costs. Let’s assume that Allan, Carlos and Joseph are all 66 years old, and each has just had a heart attack.

Each of them uses Medicare Part A and Part B, plus a Medicare supplement policy. All of them have already satisfied the Part B deductible for the year. Allan has plan A, Carlos has plan C and Joseph has plan F.

Cost sharing under Medicare Part A and Part B

All three men each spend 15 days in the hospital, followed by 22 days in a skilled nursing facility. After each gets home, he visits the doctor twice. The doctor doesn’t accept assignment. Here’s the cost sharing for each, followed by examples showing what each plan covers. All of these examples use 2016 figures.

Example: cost sharing with Parts A and B

Part A deductible	\$1,288
Part A co-insurance for two days in skilled nursing facility (\$161/day)	\$322
Part B co-insurance for two doctor’s visits (20% of Medicare-approved amount)	\$32
Part B excess charge for same two doctor’s visits (15% of Medicare-approved amount)	\$24
Total cost sharing without any Medicare supplement policy	\$1,666

Example: Allan’s plan A

Total cost sharing	\$1,666
Plan A pays:	
Part B co-insurance for two doctor’s visits (20% of Medicare-approved amount)	-\$32
Allan pays	\$1,634

Example: Carlos’ plan C

Total cost sharing	\$1,666
Plan C pays:	
Part A deductible	-\$1,288
Part A co-insurance for two days in skilled nursing facility (\$161/day)	-\$322
Part B co-insurance for two doctor’s visits (20% of Medicare-approved amount)	-\$32
Carlos pays	\$24

Example: Joseph’s plan F

Total cost sharing	\$1,666
Plan F pays:	
Part A deductible	-\$1,288
Part A co-insurance for two days in skilled nursing facility (\$161/day)	-\$322
Part B co-insurance for two doctor’s visits (20% of the Medicare-approved amount)	-\$32
Part B excess charges for same two doctor’s visits (15% of the Medicare-approved amount)	-\$24
Joseph pays	\$0

Examples of choosing a plan

Medicare offers lots of choices. You'll need to compare your needs to what's available. Here are examples and reasons why they're a good fit. Remember that costs and benefits will vary by plan; your plan may differ.

David

Meet David

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

David's wish list

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

David's choice

- (HMO) Medicare Advantage plan with built-in prescription drug coverage
- To qualify for this plan, David must be enrolled in Medicare Part A and Part B. He will continue to pay the Part B premium to Medicare

Plan features:

- Preventive care
- Free fitness program
- Built-in prescription drug benefit
- Network of local doctors and hospitals

Cost sharing

Premiums: (2016 figures)

\$121.80 per month Part B premium

\$34 per month Medicare Advantage premium (includes prescription drug coverage)

Total: \$155.80 per month

Other cost sharing: David pays his cost sharing as determined by the plan. Total spending depends on services and drugs used.

Juanita

Meet Juanita

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

Juanita's wish list

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

Juanita's choice

- Original Medicare Parts A and B
- Stand-alone Medicare Part D prescription drug plan
- Medicare supplement insurance plan (Policy F)

Plan features:

- Access to doctors and hospitals throughout the United States
- Discounted prices on the drugs she takes
- Help with her Part A and Part B deductibles and co-insurance

Cost sharing

Premiums: (2016 figures)

\$121.80 per month Part B premium

\$32 per month Medicare Part D prescription drug plan premium

\$150 per month Medicare supplement plan F policy premium

Total: \$303.80 per month

Other cost sharing: Medicare supplement policy covers most of Part A and Part B cost sharing. Juanita covers drug plan cost sharing and the costs not covered by the Medicare supplement policy.

Georgia

Meet Georgia

Georgia will be 65 next month. She has been working part-time since her husband died five years ago, but her income is limited. Georgia has heart disease, so she sees a heart specialist regularly and takes a blood-thinning medicine every day. She cannot afford a Medicare supplement policy.

Georgia's wish list

- Health care at an affordable price
- Access to her trusted doctors
- Discounted prices on her prescription drugs

Georgia's choice

- Medicare Part A and Part B
- Stand-alone Medicare Part D prescription drug plan

Plan features:

- Access to the doctors and hospitals she uses now
- The possibility of help with her premiums and cost sharing if she qualifies for low-income assistance

Cost sharing

Premiums: (2016 figures)

\$121.80 per month Part B premium

\$32 per month Medicare Part D prescription drug plan premium

Total: \$153.80 per month

Other cost sharing: Georgia pays drug plan cost sharing and all costs not covered by Part A and Part B in addition to her Part A and Part B deductibles. If Georgia qualifies for financial help, her cost sharing could be significantly lower.

Leroy

Meet Leroy

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

Leroy's wish list

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

Leroy's choice

- Medicare Advantage Special Needs Plan (SNP) for people with diabetes, with built-in prescription drug coverage. To qualify for this plan, Leroy must be enrolled in Medicare Part A and Part B. He will continue to pay the Part B premium to Medicare

Plan features:

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

Cost sharing

Premiums: (2016 figures)

\$121.80 per month Part B premium

\$24 per month Medicare Advantage Special Needs Plan premium

Total: \$145.80 per month

Other cost sharing: Leroy pays his cost sharing as determined by the plan. Total spending depends on services and drugs used.

Decision road map

Things to consider before you decide

1

Study what's available

Taking care of your health isn't a spectator sport. Choosing Medicare coverage is an important decision. You'll need to do some research to get it right.

Reading this guide is a good start, but you'll probably want to learn more. There are lots of resources available to help you do this research — the official Medicare website, Medicare books, your State Health Insurance Assistance Program (SHIP) and much more.

► Page 56

Be proactive about investigating what's available in your area.

Don't wait for advertising brochures to come in the mail. You can use Medicare's website to find and compare plans in your area.

You can also call the Medicare Helpline or your local SHIP program to find out what plans are available in your area.

Talk to your family and friends about the Medicare coverage they have now. And if you have health care coverage now from an employer, talk to your company benefits manager about your options.

2

Take a good look at yourself

While you're doing research, gather information about yourself that can help you make a good choice. You'll need to consider at least these items.

- **How's your health?** Are you in good health generally, or do you have chronic conditions?
- Do you take **prescription drugs** regularly? Which ones? How much are you spending for them?
- **What doctors do you regularly see?** Who, where, for what kind of care? How would you feel about seeing a new doctor?
- **How much do you travel?** Where? Inside or outside the United States?
- **Are you eligible for any health care coverage besides Medicare?** You may find that you want to keep some of that coverage
- **How much did you spend on medical care last year?** That total can help you estimate next year's costs
- **How does health care fit into your budget?** Will you need financial help to afford Medicare premiums? How much will you be able to spend a year on your share of the costs? Even if you don't need help with premiums, do you want to have a plan that covers as many financial gaps as possible?

3

Look for a good fit ... for you

Medicare is definitely not "one size fits all." There are lots of choices, and there are important differences among the choices.

Decide what you want. Do you want Medicare Part A and Part B, with or without a stand-alone Medicare Part D prescription drug plan, or a Medicare Advantage plan, with or without prescription drug coverage? Then compare your needs to what's out there to find a good match.

4

Look for help if you need it.

You can get help comparing and choosing plans. ► Page 58

Extra **financial help** is available with the costs of Medicare for those with lower incomes. If you think you might qualify, apply as soon as you can. It can take several months to process your application, and you'll want to find out if you're eligible, and how much help you qualify for. ► Page 58

5

Act quickly when the window opens and you become eligible for Medicare

Don't miss your initial enrollment period. ► Page 44

- Make sure your coverage begins when you want it to
- Avoid paying more in premiums because you waited

Help for people with lower incomes

Help is available for people with low incomes and few assets. If you qualify, you can get help with most of the costs that Medicare doesn't cover. If you think you might qualify, you ought to apply. It's estimated that less than half of the people who are eligible for help sign up. Contact your local Social Security Administration office or your state's Medical Assistance or Medicaid office.

Programs

Medicaid is the most talked-about assistance program, but there are others.

Medicaid helps pay costs not covered by Medicare and may include some additional benefits that Medicare doesn't cover, such as prescription drugs, eye care or long-term care.

Medicare Savings Program helps people pay their Part A and Part B premiums, deductibles and co-insurance amounts.

Program of All-Inclusive Care for the Elderly (PACE) combines medical, social and long-term care services for the frail elderly who live in and get their health care services in the community, not in a nursing home. This joint Medicare and Medicaid program is not yet available in all states.

Prescription drug premium assistance programs help people pay some or all of their Medicare Part D premiums and cost sharing. Programs include the Extra Help or low-income subsidy program offered by the federal government.

There may be other programs available in your state.

Who's eligible?

Eligibility depends on your income — money you get from retirement benefits or other money that you report for tax purposes. The government also looks at your assets (for example, property other than your house). States set their own income eligibility levels, but the average is close to \$17,655 per year for an individual, or \$23,895 for a couple.

Next steps

To learn about programs available in your state and what the eligibility requirements are, contact your local Social Security Administration office or state Medical Assistance or Medicaid office.



For singles, help may start when income is around \$17,655.

For couples, help may start when combined income is around \$23,895.

Enrollment windows and timing

Timing matters when you're joining Medicare. When you turn 65 or otherwise become eligible for Medicare, enrollment windows open. But some of these windows will close quickly. If you wait until later to sign up, you may have fewer choices and you may pay more. Here's a look at when to enroll.

When can I enroll initially?

What if I'm late?

Medicare Part A



Any time after you are 64 years and nine months old or otherwise become eligible for Medicare. Enrollment is automatic if you already get Social Security benefits. Otherwise, you'll have to enroll at your local Social Security office.

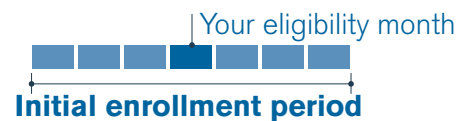
There are no penalties for signing up late, unless you are one of the people who pay a monthly premium for Part A because neither you nor your spouse contributed enough to Social Security. Then you may pay a penalty on your premium for signing up late.

Medicare Part B



Seven-month window

Any time from three months before you become eligible for Medicare until three months after your eligibility month.



If you enroll after the initial enrollment period, premiums will be higher unless you qualify for an exception. Contact Medicare to learn about exceptions.
▶ Page 58

Medicare Part C (Medicare Advantage)



Seven-month window

Any time from three months before your eligibility month until three months after your eligibility month.



If you miss the enrollment window, you must wait to enroll between October 15 and December 7, unless you qualify for an exception.

Medicare Part D



Seven-month window

Any time from three months before your eligibility month until three months after your eligibility month.



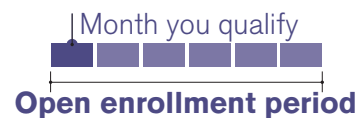
If you miss your enrollment window, you must wait to enroll between October 15 and December 7, unless you qualify for an exception. Enroll later and premiums could be higher.

Medicare supplement (Medigap) insurance



Six-month window for guaranteed right

When you turn 65 and enroll in Medicare Part B, you have a guaranteed right to buy a Medicare supplement policy for six months. You cannot be refused if you sign up during this open enrollment period.



If you miss the window, you can apply later at any time. But you may be charged a higher rate or rejected if you have a health history that makes you appear to be a higher risk.

Switching plans

Plan to review your Medicare coverage once a year to see if it still meets your needs. You can switch plans each year. Here's how.

Counting optional add-ons, there are seven possible combinations of Medicare coverage. As a general rule, you can only switch from one combination to another at certain times of the year.



Parts A and B



Parts A and B
plus stand-alone Medicare Part D drug plan



Parts A and B
plus stand-alone Medicare Part D drug plan
plus Medicare supplement insurance



Parts A and B
plus Medicare supplement insurance



Part C Medicare Advantage
with built-in drug plan



Part C Medicare Advantage



Part C Medicare Advantage
plus stand-alone Medicare Part D drug plan
(only if you choose a PFFS or MSA plan)

During the Medicare Open Enrollment Period from **October 15 through December 7**, you can add, drop or change your Medicare Part D prescription drug coverage. This is the only time of the year when you can do this, unless you qualify for an exception. In this period, you can also join or change your Medicare Advantage plan.

If you enroll in a Medicare Advantage plan during the Medicare Open Enrollment Period from October 15 through December 7, you have until February 14 of the following year to disenroll. If you disenroll, you will return to Original Medicare (Parts A and B). If prescription drug coverage was included in your Medicare Advantage plan, you will be able to enroll in a Medicare Part D plan during this time.

Making an exception

There are some exceptions to the general rule that you can change your coverage only at certain times of the year.

In some cases you will have the right to change your coverage without waiting until the next Medicare Open Enrollment Period.

If you have a Medicare Advantage plan, for example, and you move out of your plan's service area, you will have a chance to change your coverage without waiting for the next Medicare Open Enrollment Period.

If your circumstances change, don't assume you must wait until the next Medicare Open Enrollment Period. Call the Medicare Helpline and ask about exceptions to the timing rules that might apply to you. ▶ Page 58



Tip

You can add or drop Medicare supplement coverage at any time. If you change policies, it's best to wait until the new policy is effective before dropping the old policy.

Reading the cards

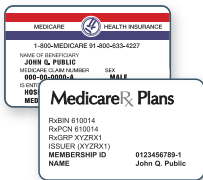
Already have Medicare but not sure about what type of coverage you have? Think about what kind of identification card you show to your doctor or hospital when you need care.



If you use only your Medicare card issued by the federal government, you probably have Original Medicare (Part A and Part B).



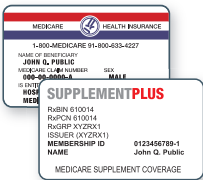
If you use a different card from your Medicare card to pay for health care services, you probably have a Medicare Advantage plan.



If you carry a separate card from a drug plan, you also may have a stand-alone Medicare Part D prescription drug plan. You might also have a discount card for drugs, but that does not mean you have a Medicare Part D plan.



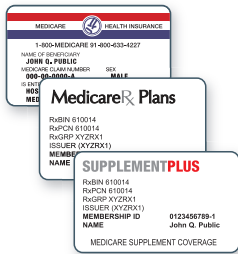
If you also use your Medicare Advantage card to pay for prescription drug purchases, you probably have a plan that includes Medicare Part D prescription drug coverage.



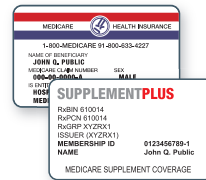
If you use your Medicare card plus a second card that pays expenses Medicare doesn't, then you probably have a Medicare supplement (Medigap) policy that you purchased on your own, or which may be provided by your former employer.



If you use a separate card to pay for prescription drug purchases, you probably have a Medicare Advantage plan (either a Private Fee-For-Service or Medical Savings Account) with a stand-alone Medicare Part D prescription drug plan.



If you purchased optional add-ons, you may have three cards — Original Medicare, a stand-alone Medicare Part D prescription drug plan, and a Medicare supplement policy.



If you use your Medicare card plus a second card that pays expenses Medicare doesn't, then you probably have a Medicare supplement (Medigap) policy that you purchased on your own, or which may be provided by your former employer.



Tip

If you still have questions about the type of insurance you have, call the Customer Service number on your ID card.

Using your Medicare benefits

Helpful tips



Keep your Medicare card safe

You'll usually need to show your Medicare card (or your Medicare Advantage plan card, if you choose Medicare Advantage) when you receive services. Bring it along when you go to the doctor.



Help prevent fraud

Your Medicare card and your Social Security number are valuable personal information. Keep track of your card. Handle it the way you would handle other valuable information, like a credit card.

If you suspect someone else is using your Medicare card or your Social Security number, call the Medicare Helpline immediately.

► Page 58



Choose your providers carefully

The quality of care may vary among doctors, hospitals and other providers.

To find quality information about providers in your area, visit **Medicare.gov** or call the Medicare Helpline.

► Page 58



Understand how coverage works

In general, for Medicare to cover a service or supply:

- You must have joined the part (Part A or Part B) that provides the service or supply
- The service or supply must be medically necessary to treat a health condition or prevent it
- You must choose a provider enrolled in Medicare
- You must meet any conditions that apply (such as limits on how often the service can be provided)

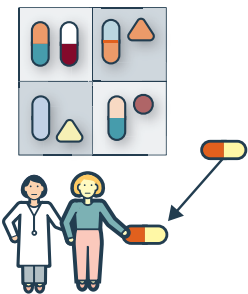
If you have questions, ask

You have the right to information about how your Medicare benefits work, including information about what services are covered and their costs. You also have the right to an explanation when a service is denied to you.

Pay attention to the paperwork

When you receive a health service that Medicare covers, you will get a Medicare Summary Notice (MSN) in the mail. The MSN shows the services or supplies that have been billed to Medicare for your care. Check this list to make sure that you received all the services or supplies listed.

Formulary



Know your rights

Smart consumers understand their rights. As a person with Medicare coverage, you have the formal right to complain, or appeal, about your treatment in certain situations. For example, you have the right to appeal when your prescription drug plan doesn't cover a drug that you and your doctor think you should have. As another example, you have the right to question the amount that Medicare paid for a service you got.

Your state's SHIP program can tell you more about how to file an appeal. ► Pages 56–57



Tip

Most health care providers are honest and bill only for services they actually provide. Some providers, however, commit "billing fraud" on Medicare by billing for services that were never provided.

If you suspect Medicare is being billed for services you didn't receive, call the Medicare Helpline or the Fraud Hotline of the Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477).

Help with care at the end of your life

Most Medicare services help you get the care you need to cure an illness and return to an active life. Sometimes, though, you may encounter a condition so debilitating that the likelihood of a cure is very small. If your condition is so serious that your life expectancy is six months or less, your doctor may feel your needs are best met by a Medicare-certified hospice care program.

Medicare's hospice care services are designed to make the last months of your life as comfortable as possible. You'll receive care intended to meet not only your physical needs, but also the emotional, social, and spiritual needs of you and your loved ones.

Hospice care is provided under Part A of Medicare as an alternative to curative care. Hospice care services cover regular visits from a team of professionals that will include nurses, doctors, nursing assistants, social workers, chaplains and trained volunteers. Hospice care also covers the drugs you use, medical supplies, and medical equipment like walkers and wheelchairs.

If you choose hospice care, Medicare no longer covers treatments intended to cure your condition. Instead, Medicare will pay 100% of the cost of your hospice care. Most important, if you change your mind about hospice care, you can return to Medicare's curative care services at any time.

How hospice care works

If you choose hospice care, you and your family will need to select a Medicare-approved hospice program in your area. Your doctor and the hospice program's medical director must then certify the existence of a terminal illness, which is a condition that will likely result in a life expectancy of approximately six months or less, should the illness run its normal course.

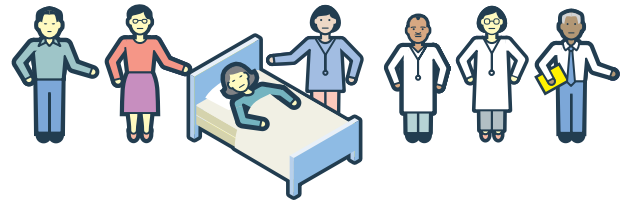
Your hospice program then creates a special team of health care professionals who will care for you wherever you call home. This can be a family home, nursing home, or assisted living facility. Hospice services are available 24 hours a day, 7 days a week.

► Page 58

Your hospice care team sets up a plan of care especially for you. This plan is designed to control your symptoms and manage pain. You'll receive most of your care in your home. Your care may also include short-term stays in a hospital or nursing home, though, if your care cannot reasonably be managed or supervised in your home, or if your family caregivers need a respite, or a short break.

Finding a hospice care program

You can learn more, or find a hospice care program in your area, by calling state and national hospice organizations. ► Page 58



A hospice team can include health care professionals, social workers, chaplains and trained volunteers.

Frequently asked questions

I get lots of brochures about Medicare Advantage plans and Medicare supplement policies in the mail, but I still have questions. Where can I find out more about how these plans and policies work?

You can get more information about these plans from Medicare through either the Medicare telephone helpline or the Medicare website. The Medicare website includes an online “Find and compare plans” tool. Your state’s SHIP program can help you learn more about these plans, too. ▶ Pages 56–57

You can also learn more about a specific plan or policy by calling customer service at the private company that offers it. You can find customer service numbers for companies in your area on the Medicare website, or you can get the numbers by calling the Medicare telephone helpline or your state’s SHIP program.

When you call customer service, ask to see a “Summary of Benefits” for a Medicare Advantage plan, or, if you’re interested in a Medicare supplement policy, ask for an “Outline of Coverage.” This document will give you a summary of what’s covered under the plan and what the cost sharing is.

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

First, find out whether you could keep any coverage you have now after you retire. If you can keep the coverage, you’ll also want to find out if it can be combined with Medicare’s coverage, and what the costs might be if you do combine them. If you can keep some of the coverage you have now, you may have more choices than the standard ones described in this guide.

You’ll need to talk with someone who’s familiar with the details of the plan you have now. If your coverage is a benefit from an employer or a union, talk to the human resources or benefit manager. If you have individual insurance you’ve been buying yourself, call customer service at the insurance company that provides the plan. Choose carefully. In some cases, if you keep your current coverage and join Medicare later, you may have fewer choices and pay more. You may also find that if you give up coverage you have now, you may not be able to get it back later.

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

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

Find out whether your spouse’s current health coverage can cover you after your spouse retires. For example, you may be eligible for COBRA coverage for up to 36 months. And look for health insurance offered by groups you belong to, like a social or professional organization or an alumni association. You may also be able to purchase individual health insurance policies.

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

If you qualify, you can receive financial help with Medicare premiums and other costs, like deductibles and co-pays. Contact your local Social Security Administration office or state Medical Assistance (Medicaid) program to find out if you qualify for help. ▶ Page 58

I’m looking at a Medicare Advantage plan, but I don’t know if my doctors belong to the plan I’m interested in. How do I find out?

Call the plan’s customer service number, and ask whether your doctors participate in the plan. You can find customer service numbers on the Medicare website or on the Medicare telephone helpline. You can also call your doctor’s office. Ask for the person who handles the doctor’s insurance billing, and then ask whether the doctor accepts the plan.

Frequently asked questions (continued)

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

Your Medicare Advantage plan will notify you if your doctor leaves the plan's network. You'll be able to choose a new doctor. Generally, you aren't able to change plans in this situation until the next Medicare Open Enrollment Period begins (unless you qualify for an exception). ▶ Page 45

Right now I have Original Medicare plus a Medicare supplement policy. If I join a Medicare Advantage plan, what are my options for handling my Medicare supplement policy? If I drop it, can I get it back?

You can keep your Medicare supplement policy after you join a Medicare Advantage plan, but you may not get much benefit from it, and you'll have to keep paying the Medicare supplement policy's premium. You won't be able to use the Medicare supplement policy to pay any cost sharing (like deductibles, co-pays or co-insurance) under the Medicare Advantage plan. Your Medicare supplement policy can only help you with deductibles, etc., under Original Medicare Parts A and B.

If you drop your Medicare supplement policy, you can apply for another later whenever you like. However, you are buying a new policy, and you can be charged a higher premium or refused entirely. There are certain limited situations in which you have the right to buy a policy regardless of your health.

Your state's SHIP program can help you decide what to do with your Medicare supplement policy in this situation. Because Medicare supplement policies are private insurance policies regulated by state insurance departments, the rules about buying Medicare supplement policies may vary in your state.

▶ Pages 56–57

What kinds of drugs aren't covered by Medicare Part D prescription drug plans?

Medicare's guidelines for prescription drug plans say that certain types of drugs may be excluded from all prescription drug plans.

These types of drugs are excluded:

- Drugs used for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription drugs
- Inpatient drugs
- Barbiturates (sleeping pills)
- Benzodiazepines (central nervous system depressants)
- Erectile dysfunction drugs

Some prescription drug plans do cover some of these types of drugs. These plans are called "enhanced" plans.

In addition, a drug cannot be covered under a prescription drug plan if payment for that drug is available under Part A or Part B of Medicare. An example is drugs that are administered in a hospital or physician's office, such as chemotherapy drugs.

Each prescription drug plan may have additional specific exclusions from its formulary, or list of drugs covered. ▶ Page 34

What happens if I join a Medicare Advantage plan where I live now, and then I decide to move? Can I take my plan with me?

That depends on where you're moving. If you're moving within the area your current plan serves (its service area), you can keep the plan. If you're moving out of the area your plan serves, you'll need to find out what your options are. They may include choosing a new Medicare Advantage plan from the plans available in the area you're moving to, or returning to Medicare Part A and Part B (with optional stand-alone drug prescription plan and Medicare supplement policy).

You can find out whether your new home is in your current plan's service area by calling customer service at your current plan.

Glossary

accepting assignment

In Part B, a doctor “accepts assignment” when he or she agrees to take payment of the Medicare-approved amount as payment in full for a service. If a doctor accepts assignment, your share of the cost is limited to your co-insurance payment (usually 20% of the Medicare-approved amount). ▶ Page 16

See “Medicare-approved amount.”

balance billing

In Part B, an additional payment you make to a doctor who doesn’t accept assignment. The doctor may not bill you more than an additional 15% of the Medicare-approved amount. Some states limit balance billing to a smaller percentage or forbid it entirely. Another name for balance billing is “excess charges.” ▶ Page 16

See “accepting assignment.”

benefit period

In Part A, a period of time that begins when you enter a hospital for an overnight stay and ends when you have been out of the hospital for 60 days in a row. ▶ Page 12

brand-name drug

A prescription drug that is sold under a trademarked brand name.

See “generic drugs.”

catastrophic coverage

In Medicare Part D, a name for the step of a drug plan in which you pay only a small co-insurance or small co-pay for a covered drug, and your plan pays the rest of the cost for the remainder of the year. You reach catastrophic coverage once you, or another individual on your behalf, have spent \$4,850 (2016) in total out-of-pocket costs for your covered drugs in a single year.

Centers for Medicare & Medicaid Services (CMS)

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

co-insurance

A kind of cost sharing where costs are split on a percentage basis. For example, Part B might pay 80%, and you would pay 20%. ▶ Page 8

coordinated care

In Part C, health care plans that coordinate your care by the doctors and hospitals you visit. You may have to choose specific doctors and hospitals. You may also hear these plans referred to as “managed care” plans.

▶ Pages 18 and 23

co-payment

A kind of cost sharing where you pay a preset, fixed amount for each service. In a Medicare Part D plan, for example, you might pay \$7 for each prescription you receive. Sometimes called a “co-pay.” ▶ Page 8

cost sharing

A term for the way Medicare shares your health care costs with you. The most common types of cost sharing are deductibles, co-pays and co-insurance.

▶ Page 8

coverage gap

A name for the step in a Medicare Part D plan in which you pay most of the plan’s discounted cost for your covered medication. You will pay 58% of the cost of generic drugs and about 45% of the cost of most brand-name drugs. The standard Medicare Part D benefit design provides that you enter the coverage gap when you and the plan together have paid \$3,310. However, these specific amounts can vary by plan. When you have spent \$4,850 (2016) in total out-of-pocket spending in a single year (including any deductibles, co-pays, co-insurance or other payments but excluding premiums), you have made it through the coverage gap and would enter the stage called catastrophic coverage. ▶ Page 32

Glossary (continued)

creditable drug coverage

Prescription drug coverage, from a plan other than a Medicare Part D stand-alone plan or a Medicare Advantage plan with drug coverage, which meets certain Medicare standards. If you are currently enrolled in a drug plan that gives you prescription drug coverage, your plan will tell you if it meets the requirements for creditable drug coverage.

custodial care

Care that provides help with the activities of daily living, like eating, bathing or getting dressed. Most long-term care is custodial care. ▶ Page 10

deductible

A kind of cost sharing where you pay a preset, fixed amount first, before Medicare or other insurance starts to pay. In Part B in 2016, for example, you must pay a deductible of \$166 for the year. ▶ Page 8

dual eligible

A person who is eligible for both Medicare and Medicaid.

formulary

A list of the prescription drugs that are covered by a Medicare Part D plan. ▶ Pages 34–35

generic drug

Prescription drugs that have the same active ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

See “brand-name drug.”

guaranteed renewable policy

A feature of Medigap policies. A “guaranteed renewable” policy must be renewed by the company automatically each year, so long as you pay the premium and don’t commit any fraud on the insurance company.

Health Maintenance Organization (HMO) plan

In Part C, a type of Medicare Advantage plan in which you must use doctors and hospitals in the plan’s network for your care. If you go outside the network, other than for emergency care, for urgent care, or for renal dialysis, you are responsible for paying for your own care. ▶ Page 23

high-deductible Medicare Advantage plan

A health insurance plan in which you pay a significant deductible (usually more than \$1,000) before the plan begins to help with your costs. See “Medical Savings Account (MSA) plans.”

home health care

In Part A and Part B, skilled nursing care and therapy, such as speech therapy or physical therapy, provided to the homebound on a part-time or intermittent basis.

hospice care

Care for those who are terminally ill. Hospice care typically focuses on controlling symptoms and managing pain. In Part A, hospice care also includes support services for both patient and caregivers.

Part A covers both hospice care received at home and care received in a hospice outside the home.

initial enrollment period

When you first become eligible, a seven-month period that begins three months before the month you turn 65 or otherwise become eligible and ends three months after the month you become eligible. During your initial enrollment period, you will be able to sign up for Medicare plans that may either be unavailable or cost more if you wait until later to join. ▶ Page 44

inpatient care

Care you receive in a hospital when you are admitted for an inpatient stay.

Late Enrollment Penalty (LEP)

The dollar amount added to your Part D premium. If you did not have creditable drug coverage for 63 days or more and you did not enroll during your initial enrollment period or the Open Enrollment Period, you will pay a LEP unless you qualify for an exception.

lifetime reserve days

In Part A, a reserve of 60 days of care that Part A will pay for during your lifetime. You can choose to use lifetime reserve days any time you stay in a hospital longer than 90 days. A lifetime reserve day cannot be replaced. When it is used up, it is gone.

► Page 12

long-term care

Care that gives help with the activities of daily life, like eating, dressing and bathing, over a long period of time. Most long-term care is custodial care.

See “custodial care.”

maximum out-of-pocket limit

A limit that Medicare Advantage plans set on the amount of money you will have to spend out of your own pocket in a plan year. In Medicare Part D, this is the maximum amount of money you will have to spend out of your own pocket before catastrophic coverage begins for the remainder of the year.

See “catastrophic coverage.”

Medicaid

A program that pays for medical assistance for certain individuals and families with low incomes and few resources. Medicaid is jointly funded by the federal and state governments and managed by the states. Medicaid includes programs that help eligible persons pay Medicare premiums and cost sharing.

See “dual eligible and Medicare Savings Program.”

Medical Savings Account (MSA) plans

In Part C, a type of Medicare Advantage plan that combines a special bank savings account for your medical expenses with a high-deductible Medicare Advantage plan. ► Pages 28–29

See “high-deductible Medicare Advantage plan.”

medically necessary care

Services or supplies that are needed to diagnose or treat a medical condition, according to the accepted standards of medical practice. ► Page 10

Medicare

A federal government health program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant)

Medicare Advantage

In Part C, a type of plan offered by a private company. In Medicare Advantage plans, a single plan provides you with both hospital and doctors’ care. Many Medicare Advantage plans also include prescription drug coverage. ► Pages 18–29

Medicare Advantage disenrollment period

If you enroll in a Medicare Advantage plan during the Medicare Open Enrollment Period from October 15 through December 7, you have until February 14 of the following year to disenroll. If you disenroll, you will return to Original Medicare (Parts A and B). If prescription drug coverage was included in your Medicare Advantage plan, you will be able to enroll in a Medicare Part D plan during this time.

Medicare-approved amount

The amount of money that Medicare has approved as the total amount that a doctor or hospital should be paid for a particular service. The total amount includes what Medicare pays, plus any cost sharing you pay. ► Page 16

See “accepting assignment.”

Medicare Open Enrollment Period

The period from October 15 through December 7 of each year. During the Medicare Open Enrollment Period, you may enroll in or change prescription drug plans and Medicare Advantage plans. ► Page 44

Glossary (continued)

Medicare Savings Program

Medicaid program that helps eligible people pay some or all Medicare premiums and deductibles.

Medicare SELECT

A special type of Medicare supplement policy that requires you to use specific hospitals, and, in some cases, specific doctors, to get your full insurance benefits (except in an emergency).

Medicare supplement policy

Also called Medigap. An insurance policy you buy from a private insurance company that pays for some or all of the cost sharing, or gaps in coverage, such as deductibles, co-pays and co-insurance, in Medicare Part A and Part B coverage. Medicare supplement policies are available in standard types or plans. Each plan is named with a letter of the alphabet. Don't confuse plans A, B, C and D with Parts A, B, C and D of Medicare. ▶ Pages 36–39

network

In Part C and Part D, the group of health care providers, such as hospitals, doctors and pharmacies, that agree to provide care to the members of a Medicare Advantage coordinated care plan or prescription drug plan. These providers are called network providers and network pharmacies.

▶ Page 23

outpatient care

Care you receive as a hospital patient if you are not admitted for an inpatient stay, or care you receive in a freestanding surgery center as an outpatient.

PACE

An abbreviation for Program of All-Inclusive Care for the Elderly. A program that helps frail seniors live independently in their communities for as long as possible by providing them with a combination of medical, social and long-term care services. PACE is available only in states that have chosen to offer it as part of their Medicaid program.

See “Medicaid.”

Part A

The part of Original Medicare that provides help with the cost of hospital stays, skilled nursing services following a hospital stay and some other kinds of skilled care. Don't confuse this with a Medigap plan A, which is a type of Medicare supplement policy. ▶ Pages 10–13

Part B

The part of Original Medicare that provides help with the cost of doctor visits and other medical services that don't involve overnight hospital stays. ▶ Pages 14–17

Part C

The part of Medicare that allows private insurance companies to offer plans that combine help with hospital costs with help for doctor's visits and other medical services. Part C plans are usually referred to as “Medicare Advantage” plans. ▶ Pages 18–29 See “Medicare Advantage.”

Part D

The part of Medicare that offers help with the cost of prescription drugs. You can get Medicare Part D coverage as a stand-alone drug plan or as part of a Medicare Advantage plan. ▶ Pages 30–35

Point of Service (POS) plan

In Part C, a type of Medicare Advantage HMO plan that allows members the ability to visit doctors and hospitals outside their network for some covered services, usually for a higher co-payment or co-insurance. Some POS plans do not require referrals for specialty services.

pre-existing condition

When you are applying for an insurance policy, a name for an illness or medical condition you currently have. ▶ Page 37

Preferred Provider Organization (PPO)

In Part C, a type of Medicare Advantage plan in which you can use either doctors and hospitals in the plan's network, or go to doctors and hospitals outside the network. If you go outside the network, you'll usually pay a larger share of the cost of your care. ▶ Page 23

premium

A fixed amount you have to pay to participate in a plan or program; in private insurance, the price you pay for a policy, usually as a monthly payment. ▶ Page 8

prescription drug plan (PDP)

In Medicare Part D, a stand-alone insurance policy that helps with the cost of prescription drugs. ▶ Page 30

preventive care

Care that is meant to keep you healthy, or to find illness early, when treatment is most effective. Examples of preventive care are flu shots, mammograms screenings and diabetes screenings.

Private Fee-For-Service Plan (PFFS)

In Part C, a type of Medicare Advantage plan in which there is usually no network of providers and you may visit any Medicare-eligible provider who is willing to accept the plan's payment terms and conditions. ▶ Pages 26–27

provider

A person or organization that provides medical services and products, such as a doctor, hospital, pharmacy, laboratory or outpatient clinic.

retiree health coverage

Group health insurance coverage provided by a company or other plan sponsor for employees who have retired.

service area

In Part C, the area where a Medicare Advantage plan offers service. A service area is typically a county, state or region. ▶ Page 18

skilled nursing care

Nursing care which should be provided only by a licensed nurse.

Special Needs Plan (SNP)

A type of Medicare Advantage plan that serves people with special health care needs. ▶ Pages 24–25

step therapy

In Medicare Part D, a special procedure you and your doctor must follow before you can use certain drugs. You must first try a less expensive drug to see if it works for you. You may “step up” to a more expensive drug that treats the same condition only if you and your doctor can show that the less expensive drug didn't work for you. ▶ Page 35

tiered formulary

In Medicare Part D, a drug plan formulary that divides drugs into groups. Each group, or tier, has a different level of cost sharing. For example, a generic version of a drug may have a lower co-pay than a brand-name version of the drug. The details of the cost sharing vary from plan to plan. ▶ Page 35

True Out-of-Pocket (TrOOP) costs

The amount you pay or others pay on your behalf toward the cost of your prescription drugs including deductible, co-pays, co-insurance and payments made in the coverage gap. Premiums do not count toward True Out-of-Pocket costs.

Resources

State Health Insurance Assistance Program (SHIP) offices

Each state has an agency that offers free counseling about choosing Medicare coverage. Here are the telephone numbers.

Alabama

1-800-243-5463
1-334-242-5743
1-334-242-0995 (TTY)

Alaska

1-800-478-6065
1-907-269-3680
1-907-269-3691 (TTY)

Arizona

1-800-432-4040
1-602-542-6366 (TTY)

Arkansas

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

California

1-800-434-0222
In-state calls only

Colorado

1-888-696-7213
1-303-894-2946
1-866-665-9668 (Español)

Connecticut

1-800-994-9422
In-state calls only
1-860-842-5424 (TTY)

Delaware

1-800-336-9500
In-state calls only
1-302-674-7364

Florida

1-800-963-5337
1-850-414-2060
1-800-955-8771 (TTY)

Georgia

1-866-552-4464
1-404-657-1929

Guam

1-671-735-7382

Hawaii

1-888-875-9229
1-808-586-7299

Idaho

1-800-247-4422
In-state calls only

Illinois

1-800-548-9034
In-state calls only
1-217-785-9021

Indiana

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

Iowa

1-800-351-4664
1-515-281-5705
1-800-735-2942 (TTY)

Kansas

1-800-860-5260
1-316-337-7386

Kentucky

1-877-293-7447

Louisiana

1-800-259-5300
In-state calls only
1-225-342-5300

Maine

1-877-353-3771
In-state calls only
1-207-621-0087

Maryland

1-800-243-3425
In-state calls only
1-410-767-1100
1-800-637-4113 (TTY)

Massachusetts

1-800-243-4636

Michigan

1-800-803-7174
1-517-886-1242

Minnesota

1-800-333-2433

Mississippi

1-800-948-3090
1-601-359-4956

Missouri

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

Montana

1-800-551-3191
In-state calls only

Nebraska

1-800-234-7119
1-402-471-2841

State Health Insurance Assistance Program (SHIP) offices

Nevada

1-800-307-4444
1-702-486-3478

New Hampshire

1-866-634-9412

New Jersey

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

New Mexico

1-800-432-2080
In-state calls only
1-505-476-4846

New York

1-800-701-0501

North Carolina

1-855-408-1212
1-919-807-6900

North Dakota

1-888-575-6611
1-701-328-2440

Ohio

1-800-686-1578

Oklahoma

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

Oregon

1-800-722-4134
In-state calls only
1-503-947-7979
1-800-735-2900 (TTY)

Pennsylvania

1-800-783-7067
1-717-783-8975

Puerto Rico

1-877-725-4300
1-787-721-6121

Rhode Island

1-401-462-0510
1-401-462-0740 (TTY)

South Carolina

1-800-868-9095
1-803-734-9900

South Dakota

1-800-536-8197
1-605-773-3656
1-605-367-5760 (TTY)

Tennessee

1-877-801-0044
1-615-532-3893 (TTY)

Texas

1-800-252-9240

Utah

1-800-541-7735
In-state calls only
1-801-538-3910

Vermont

1-800-642-5119
In-state calls only
1-802-748-5182

Virgin Islands

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

Virginia

1-800-552-3402
1-804-662-9333

Washington

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

Washington D.C.

1-202-994-6272
1-202-994-6656 (TTY)
1-202-739-0668 (Español)

West Virginia

1-877-987-4463
1-304-558-3317

Wisconsin

1-800-242-1060
1-888-701-1255 (TTY)

Wyoming

1-800-856-4398

Get answers.

Go to **MedicareMadeClear.com**

Medicare

Medicare Helpline

For questions about Medicare and detailed information about plans and policies available in your area, call: **1-800-MEDICARE** (1-800-633-4227), TTY **1-877-486-2048**, 24 hours a day, 7 days a week. Or go to: **Medicare.gov**.

Medicare & You

Official Medicare handbook for Medicare programs updated each year. You can download a copy at the Medicare website or call the Medicare Helpline to request a copy.

Online plan finders

For online tools to find and compare drug plans, Medicare Advantage plans and Medicare supplement policies, go to: **Medicare.gov**.

Social Security

Social Security Administration

For help with questions about eligibility for and enrolling in Medicare or Social Security retirement benefits and disability benefits, and for questions about eligibility for help with costs of Medicare coverage, call: **1-800-772-1213**, TTY **1-800-325-0778**, between 7 a.m. and 7 p.m., Monday through Friday.

Administration on Aging

Eldercare locator

For help in finding local, state and community-based organizations that serve older adults and their caregivers in your area, call: **1-800-677-1116** between 9 a.m. and 8 p.m. EST, Monday through Friday. Or go to: **Eldercare.gov**.

Hospice care

State hospice care organizations

For information about hospice care programs in your area, call your state hospice care organization. Call the Medicare Helpline to get the number.

Private plans

Your health plan's customer service center

For questions about your existing health coverage, call the telephone number on your identification card.

AARP

AARP website

For information about Medicare and other programs for seniors, go to: **AARP.org**.

The AARP website offers educational materials about Medicare in its health section. You can also order publications online.

American Kidney Fund (AKF)

For information on treatment-related financial assistance for patients on dialysis, as well as health information on chronic kidney disease (CKD) and resource referrals, please visit **KidneyFund.org** or call AKF's toll-free HelpLine at **1-866-300-2900**.

The mission of the American Kidney Fund is to fight kidney disease through direct financial support to patients in need, health education and prevention efforts. The American Kidney Fund leads the nation in providing charitable assistance to dialysis patients who need help with the costs associated with treating kidney failure.

State resources

Your state's Medical Assistance or Medicaid office

To learn whether you are eligible for financial help with the costs of Medicare, call your state's Medical Assistance or Medicaid office. They can answer questions about programs like PACE (Program of All-Inclusive Care for the Elderly) and the Medicare Savings Program.

You can also call the Medicare Helpline and ask the operator for the telephone number for your state's Medical Assistance or Medicaid office.

Your State Health Insurance Assistance Program (SHIP)

For help with questions about buying insurance, choosing a health plan, buying a stand-alone prescription drug plan, buying a Medicare supplement policy, and your rights and protections under Medicare, call your State Health Insurance Assistance Program office. Telephone numbers are listed on the prior pages.

This program offers free counseling for decisions about Medicare coverage. Your local office can also help you locate detailed information about the Medicare Advantage plans, drug plans and Medicare supplement policies available in your area.

In some states, this program is called the Health Insurance Counseling and Advocacy Program (HICAP).

Comparing Plans Fill out the chart below with information from private insurance companies.

Plans

Insurance company			
Name of plan			
Type of plan			

Original Medicare

Cost

Part A monthly premium			
Part B monthly premium			

Costs

Monthly premium			
Annual deductible			
Co-pays/co-insurance			
Annual deductible			
Emergency fees			
Annual deductible			
Your prescription cost on the plan			
Annual deductible			

Coverage Put a check mark in each box that the plan **will cover**. If it is not covered, leave it blank.

Current physician			
Current prescriptions			
Coverage gap			
NurseLine SM			
Preventive care			
Lab services			
Emergency services			
Outpatient care			
Hearing exams			
Dental services			
Vision services			

Interested in learning more?

Check out **MedicareMadeClear.com** to watch videos, sign up for our newsletter, take quizzes, find tools and get answers to your Medicare questions.

Stay informed:



Twitter



Facebook



YouTube



Newsletter

Additional information resources:

- Visit **Medicare.gov**
- Call **1-800-MEDICARE (1-800-633-4227)**, TTY **1-877-486-2048**, 24 hours a day, 7 days a week
- Call your local State Health Insurance Assistance Program (SHIP) to see if you qualify for any financial assistance



MedicareMadeClear.com



**Get answers.
Medicare made clear.**

 **UnitedHealthcare®**

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.