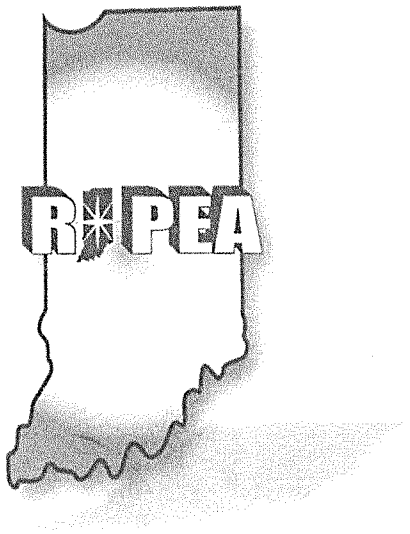
2019
SUMMARY
OF
MEDICARE PARTS
A, B, C, & D



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MEDICARE - 2019

A Summary of Parts A, B, C, & D

Medicare was signed into law by President Lyndon B. Johnson in 1965 and became law on January 1, 1966. It provided a national health plan for senior citizens over the age of 65 and under age 65 with certain disabilities. It was called Medicare. Original Medicare had two distinct parts:

Part A:	Hospital Expense
Part B	Physician Expense

I MEDICARE: PART A

A Premium: The majority of Medicare recipients don't pay monthly premiums for Part A. If the beneficiary or their spouse did not pay Medicare taxes for 40 quarters or more, buying Part A will cost more; as much as $422 per month.

B Coverage: Part A of Medicare covers:

1. Inpatient Hospital Care
2. Skilled Nursing Care
3. Home Health Care
4. Hospice Care

C Cost: Medicare A has other costs for beneficiaries, as well. The program contains deductibles, copayments, and coinsurance, similar to employer sponsored health plans. A beneficiary's overall cost will depend on the type, and amount of services, as well as the length of time of treatment.

D Medicare Part A Hospital Days:

1 Deductible: Patient Pays

- Initial Deductible: $1364
- Days 1 thru 60: Zero
- Days 61 thru 90: $341 per day
- Days 91 & beyond $682 per day

Original Medicare will cover up to ninety days of in-patient care during each benefit period. Recipients also have an additional 60 days of coverage; these are called **"Lifetime Reserve Days".** These additional days may be used once. After these days have been used, the patient pays full price.

2 Skilled Nursing Facility Care:
   a. 1st day to 20th day – No cost
   b. 21st day through the 100th day - $167.50 / day
   c. No coverage beyond the 100th day

E Part A Generally Covers:

1 Semi-Private hospital room
2 Hospital meals
3 General nursing
4 Medically Necessary:
   a. Prescriptions
   b. Supplies
   c. Equipment
5 Skilled Nursing Facility Care
6 Hospice Care
7 Home Health Care (for a specified length of time)

F Part A Generally Not Covered:

1 Custodial Care in Nursing Homes
2 Private Duty Nursing
3 Care outside the United States is not covered by Medicare, However, Medicare Supplement plans generally offer emergency Medical coverage after a $250 deductible, and will pay 80% up to a lifetime maximum of $50,000.
4 Hospital Stays for cosmetic surgery
5 Hospital Stays not medically necessary
6 Outpatient prescription drugs

G Enrollment:

1 **Eligibility:** If you have paid FICA (Social Security and Medicare) taxes for 10 years (40 quarters) you will be eligible for Medicare Parts A and B, beginning on the first day of the month during which you will turn age 65.

2 **Automatic:** If you are already drawing Social Security benefits when you are first eligible, your enrollment will be automatic.

3 **Self-Enroll:** If you are not enrolled in Social Security when first eligible for Medicare, you will need to self-enroll in Medicare. Since Medicare is effective on the first day of the month in which you turn age 65, you will need to enroll 3 months in advance of your 65th birthday. Below is the current contact information:

a. On-line: Go to ssa.gov
b. Call: Social Security: 1-800-772-1213
TTY Users: 1-800-325-0778
c. In Person: Visit a Social Security Office

4 There are **additional circumstances** that will require manual enrollment In Medicare:

a. If you have not worked at least 40 quarters, which is the minimum work requirement to get Medicare without premium.
b. If you have not paid Medicare taxes through your employer.
c. If you have end-stage renal disease before age 65 you may apply for Social Security disability regardless of age.

5 **Late Enrollment**:

a. If you are eligible for premium free Medicare Part A, you may enroll in Medicare any-time after initial eligibility, without penalty.

b. If you are not eligible for premium-free Part A, and you do not enroll in Medicare Part A during the initial 7 month enrollment period (4 months before your birthday month, your birthday month, and 3 months after your birthday month) you will need to wait until the next "Open Enrollment Period", which is January 1st to March 31st. Then Medicare effective date will be the following July1st.

II MEDICARE: PART B

A Premium: The standard monthly premium for Part B for seniors whose incomes are below $85,000 single income or $170,000 joint is $135.50, but can be as high as $460.50 for those in the highest income bracket.

B Part B Coverage:

1 Annual Deductible: $185

2 Coinsurance: After deductible is met, the beneficiary will be responsible for paying the coinsurance amount of 20% of the Medicare Approved Amount.

3 Outpatient services received at a hospital, doctor's office, clinic, or other health facility.

4 Preventive services to prevent or detect blindness at an early stage.

5 Included Services:
- a. Doctor visits (office and hospital)
- b. Laboratory Tests
- c. Diagnostic Tests
- d. Emergency ambulance service
- e. Mental health services
- f. Durable medical equipment (Outside the Hospital)
- g. Preventive Services: Pap smears, flu shots, etc.
- h. Rehabilitative services: physical therapy, speech therapy, etc.

C **Not Covered by Part B:**

1 Prescription Drugs (except in limited circumstances)
2 Routine foot care and Podiatry services
3 Routine beauty care and aids
4 Routine eye exams and prescription eye wear
5 Routine dental care, including exams, fillings, extractions, and dentures

III MEDICARE PART D

A **Background:** The Part D drug coverage was signed into law by George W. Bush and on December 8, 2003 and became effective on January 1, 2006. The legislation put forth a specific benefit plan to create the minimum level of drug coverage. Drug companies were encouraged to offer several plans, but all plans offered must, equal or exceed the base plan outlined in the legislation. Insurance carriers and drug companies were encouraged to design their own plan offerings which would allow competition to help restrain costs.

B **How and when do you enroll in Part D drug coverage:** Medicare drug coverage is available to anyone who is enrolled in Part A and Part B of Medicare. You may contact the individual drug plans directly or you can shop drug plans on Medicare .gov. This website is easy to use and provides the information that you need to determine which drug plan is the best fit for you.

C **Late Enrollment Penalty:**

1 You may be penalized if you fail to enroll in a drug plan when you are first eligible and you do not:

a. Have other creditable drug coverage or

b. Qualify for "Extra Help" (financially) to afford the cost of needed drugs.

2 The Part D late enrollment penalty is a 1% add-on to the premium for each month you were eligible for Part D coverage, but were not covered. This penalty is assessed throughout your lifetime. Although this lifetime penalty appears to be harsh, remember it is assessed against a relatively low premium amount.

Example: If you were without drug coverage for 15 months after you were first eligible, that would equate to a 15% penalty against a low cost monthly premium, maybe $39;00. Your 15% penalty ($5.85) would be added to the normally $39 monthly premium to bring your total monthly premium to $44.85. Since the penalty is percentage assessment, the dollar value of the penalty will increase each year as the premiums increase.

D **IRMAA (Income Related Monthly Adjustment Amount):** Part D enrollees with incomes above $85,000 (individually), or $170,000 (married and filing jointly), will be assessed larger costs for Medicare Part D (drug coverage).

E **Formularies:** Each Medicare drug plan has its own list of covered drugs (drug formulary). Part D drug plans categorize drugs into different "tiers" in their formularies. Drugs are assigned to tiers based on cost, with the lower cost drugs (generics) being assigned to tier 1, and brand name drugs being assigned to tier 2, or 3, with the more expensive drugs being assigned to tier 3. (Some drug plans use more than 3 tiers) However, tier 1 will always have the lowest copays, while higher numbered tiers will have increasingly higher copays relative to the cost of the drug, as illustrated below:

Tier 1 - Lower cost generic drug: = Lowest Copays
Tier 2 -Higher cost generics & lower cost brand drugs = higher copays than tier 1
Tier 3 -Higher cost brand & Lower cost specialty drugs = higher copays than tier 2
Tier 4 -Higher cost specialty drugs (higher cost than tier 4 drugs = Highest copay

NOTE: Some formularies cover only the generics, when they are available, While others may require prior approval to cover a brand name drug.

F **Changes to Formularies:** Drug formularies change almost every year. If the change Involves a drug you are currently taking, your Part D carrier must either:

1 Provide you written notification of the changes at least 60 days prior to the date the changes become effective, or

2 When you request a refill, your insurance provider must provide written notification of coverage under the prior plan.

G **Special Rules:**

1 **Prior Authorization:** You or your drug prescriber must contact the drug plan before filling certain prescriptions. The prescriber may need to provide information certifying that the drug is "medically necessary" before the prescription can be approved.

2 **Quantity Limits:** In some cases there are limits on how much of a medication can be issued with a prescription. Amounts above this level must be approved and will require information from the prescriber.

3 **Step Therapy:** A patient is required to try or have tried one or more lower cost, alternative drugs before the plan will approve the prescription. In some cases a letter from your physician certifying that you have previously tried the alternative drugs, will satisfy this requirement

4 **Part D Vaccine Coverage:** Except for vaccines covered under Medicare Part B, Medicare drug plans' formularies must include all commercially available medically necessary vaccines to prevent illnesses.

H **Drug Plan Design:**

1 **Premium:** The monthly premiums vary by RX plan design.

2 **Coverage Phase:** The coverage offered by Prescription Drug Plans will vary according to the coverage phase. Prescription Drug coverage is paid in 4 distinct phases:

a Deductible Phase
b Initial Coverage Phase
c Coverage Gap
d Catastrophic Coverage Phase

3 **Deductible Phase:** For most stand-alone Medicaid Prescription Drug Plans and Medicare Advantage Prescription Drug Plans you will pay

100% of the cost for medications until you have met the annual deductible ($415 for 2019). After the deductible, the prescription drug coverage moves ahead to the initial coverage phase.

4 **Initial Coverage Phase:** After meeting the deductible, your drug plan begins actual coverage. You will be assessed a copay or coinsurance based on the drug and the cost factor determined by the drug tier to which it is assigned. For most drugs, you will be assessed a small to moderate copay for the drug. Coverage for some drugs is determined on percentage of the cost basis. However, once you and your plan have spent a combined $3,820 for prescription drugs (including the deductible) during the calendar year for covered drugs, you have reached the initial coverage limit and then will move into the "Coverage Gap" phase.

5 **Coverage Gap Phase:** Many people do not spend enough on prescriptions annually to make it to the Coverage Gap, however, when you do, you enter the phase better known as the DONUT HOLE. In this phase the enrollee typically pays 100% of the cost of the prescription drugs, however, the Federal Government has negotiated with drug companies to reduce the cost of drugs when purchased in the "Coverage Gap". Now, while in the Coverage Gap, the average person will pay about 35% (2019) of the actual cost of a brand name drug and about 44% of the cost of generic drugs. The costs of the drugs in the "donut hole" are expected to continue to drop to approximately 25% of the actual cost by the year 2020. Once your out of pocket expense for drugs is $5100, you qualify for the "Catastrophic Phase". If your drug plan requires that you purchase all of your drugs at a particular drug company, be certain that you continue to honor that requirement because drugs purchased at other pharmaceutical companies will not count toward various phases described above.

5 **Catastrophic Coverage Phase:** Again, not everyone will reach this phase; It begins when your out of pocket costs reach $5100 (2019). During the catastrophic phase, you'll only pay a small coinsurance or copayment for covered prescription drugs for the remainder of the year. Currently, folks In the Catastrophic Coverage Phase pay 5% of the cost or a copay of $3.50 for "generic" drugs and a copay of $8.50 for "brand name" drugs.

6 **Rx Coverage Summary:**

a Deductible: Insured pay 100% of cost up to $ 415

b Initial Coverage: Insured will pay 25% coinsurance until the annual total of drug costs (including deductible) reach $3820 $ 3,405

c Coverage Gap; (Donut Hole) Insured pays approximately 35% of the cost of drugs until the member's annual out of pocket costs, (including the portion paid by the drug manufacturer discount) reaches $5100, $1,280

$5,100

IV MEDICARE ADVANTAGE PLANS NARATIVE:

A We have already presented: Medicare Parts A, B, C, and D; but now it is time to discuss the least known alternative to Medicare – MEDICARE ADVANTAGE PLANS. These plans are sometimes referred to as Part C since they were initially called "Choice Plans". These plans were designed to provide original Medicare in a different format. Original Medicare did not include prescription drug coverage, However, Medicare Advantage plans include all three coverage plans:

- Part A Hospitalization
- Part B Physician Coverage
- Part D Prescription Drug Coverage

B Just as with the separate Part D drug plans that are purchased with original Medicare, most Medicare Advantage Plan carriers make changes to their coverage designs and drug formularies almost every year. Therefore, it is also prudent to annually (during Open Enrollment – October 15th to December 7th) check the coverage, pricing and formularies available for the up-coming year to be certain your current Advantage Plan drug formulary is still the best alternative for you. This small annual exercise can save you headaches and sometimes large amounts of money during the coming year.

C Original Medicare covers enrollees at medical providers that accepted Medicare reimbursements (generally much lower than the provider's normal fees). Although the number of medical providers that take Medicare assignment is growing smaller, Medicare enrollees are not limited to a specific network of providers. However, most Medicare Advantage Plans have some type of defined network, such as Health Maintenance Organizations, HMO Point of Service Plans, Preferred Provider Networks, Private Fee-For-Service Plans, and Special Plans. Consequently, Advantage Plan participants must be aware of their plan's provider network and diligently work within their assigned provider network; using non-network providers without authorization can be very costly.

D Medicare Advantage Plans are funded primarily by Medicare, premium payments, and copays paid by the policyholders. The Medicare funding is provided to the various insurance carriers based on the average amount of claim dollars paid to Medicare recipients in that geographical area, plus a small additional amount for risk. The carrier (subject to Medicare approval) determines the coverage and drug formulary that can be economically provided by this funding. The extra "risk amount" is provided to participating carriers that agree to accept the risk of funding all costs and claims overages; therefore, they are totally accountable for the risk. Carriers appreciate this financial arrangement as it allows them the possibility of earning profits from their expertise in claims management; the Feds like it because they are not at risk for claims losses.

E Since participating insurance carriers receive Federal funding as outlined above, many of them can design benefit plans with deductibles, coinsurance and copays that result in lower claims costs; thereby allowing some Advantage Plans to be offered at no premium cost to the insured. These "zero cost" programs are very popular and can be very beneficial, especially to beneficiaries with limited income.

F The coverage offered by Medicare Advantage Plans varies by plan, but can be very comprehensive. Of course, they must cover all of the medical and hospital services included in Original Medicare. Coverage includes emergency services, urgent care, hospitalization, surgery, physician office visits, diagnostic tests, and more. Some plans also include additional coverages like dental services, hearing benefits, wellness programs and even memberships to health and exercise facilities . Also, many plans include prescription drug coverage (as previously mentioned).

G Below are the general qualifications required to participate in a Medicare Advantage Plan.

1 Must be enrolled in Medicare Part A and Part B
2 You must live in a Medicare Advantage Plan service area.
3 You cannot have end-stage renal disease
4 Exceptions to the above are determined by the individual carrier; therefore it may be worthwhile to contact local carriers for more specific information.

H Although a large majority of Medicare enrollees take Original Medicare and add a Medicare Supplement and a Part D drug plan, the number of folks enrolling in Medicare Advantage Plans are increasing every year. Both Original Medicare (with a supplement and drug plan) and Medicare Advantage Plans can offer very comprehensive coverage and still be reasonably priced. It is important for people to have affordable and yet comprehensive choices. If you have not considered a Medicare Advantage Plan, it may be worthwhile to check them out.

I Once a Medicare covered person moves from a Medicare supplement to a Medicare Advantage Plan, they must be approved through "medical underwriting" before they

are eligible to move back to a Medicare supplement plan.

J There are certain time frames when you can enroll in Medicare Advantage Plans:

1 Initial Coverage Election Period – A 7 month period beginning four months before and 3 months after the month of your 65th birthday

2 If you didn't sign up for Original Medicare during the Initial Enrollment Period (still covered by an employer or union) your Initial Coverage Election Period is the three-month period before your Medicare Part B start date, which would coincide with the date you ceased your employer or union coverage.

3 The Annual Election Period runs October 15th to December 7th each year. You can switch from Original Medicare to a Medicare Advantage Plan at that time and make other changes as well. If you're already enrolled in a Medicare Advantage Plan and want to switch to a different Advantage plan, this period is a good time to make the change. The effective date of your new plan would be the following January 1st.

4 You may be able to change to Medicare Advantage during the Special Election Periods (SEPs). This election period is triggered by "special events" such as:
- losing your current coverage
- moving to a new address
- qualifying for other coverage
- changes in your current health plan that negatively impact your coverage.

If you want to switch back to Original Medicare (Part A and Part B), you can also do so during this period or during the Medicare Advantage Disenrollment Period which runs from January 1st to February 14th, each year.