DoubleHealthUSA

RETIREE GUIDE

MEDICARE AND HEALTH CARE INSURANCE FOR RETIREES

The contents of this chapter of the retiree guide focuses on Individual Medicare and Medicare Supplemental products available to you.

The Medicare Chapter focuses on the following general topics

- General Medicare
- Products that supplement or replace Original Medicare
- Prescription Drug Coverage (Medicare Part D)
- Medicare Administration
- Other Retiree Cost Risks

Some of the complex sub-topics within the general topics include:

General Medicare
- Medicare

Products that supplement or replace Original Medicare
- Medicare Supplemental Products
- Medicare Advantage
- Medicare Special Needs Plans

Medicare Prescription Drugs
- Prescription Drug Coverage (Medicare Part D)

Medicare Administration
- Enrollment Periods and Administration

Other Retiree Cost Risks

We hope this guide will simplify some of the details of the various Medicare programs. For specific details, go to www.Medicare.gov or contact a Double Health USA representative at www.doublehealthusa.com.

If you have any questions regarding any of the topics in this guide, you can send an e-mail to dkee@doublehealthusa.com or dhusa@gmail.com. You may also call a Double Health USA representative toll-free at 1-866-600-7083.

September, 2011

MEDICARE

Medicare is the United States health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare, including those who have disabilities, permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program covers approximately 80% of the costs, but it does **not cover all medical expenses** or the cost of **most long-term care**.

Medicare is financed by a portion of the payroll taxes paid by workers and their employers. It also is financed in part by monthly premiums deducted from Social Security checks. This generally means you are eligible if you or your spouse (or, in some cases, your former spouse) worked — and paid Medicare and Social Security payroll taxes — for at least 10 years. Although full retirement age is increasing, Medicare is still available at age 65.

In most cases, you will automatically get Part A and Part B when you sign up for Social Security. Part A is free and the premiums for Part B are taken out of your Social Security check each month.

Medicare has four parts

1. **Hospital Insurance (Part A)** helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care, and hospice care.

   - There is a deductible of $1,132 for each hospital stay for the first 60 days
   - For the next 30 days, everything is covered but $238/day copay.
   - There are an additional 60 lifetime reserve days that cover all but a $566/day copay
   - Beyond 150 days, Medicare pays nothing more.
   - For mental health admissions, payments are the same as above up to 190 days.

   It is important to note that the deductible is paid by you for each benefit period. That means, if you are hospitalized three times during a year, and each admission is separated by 60 days, you will pay three deductibles. This is where you might want to consider a Medicare Advantage or a Medigap policy to pick up those extra charges. These Plans will be covered in other sections of this guide.

2. **Medical Insurance (Part B)** helps pay for doctors' services, tests, outpatient care, durable medical equipment, physical therapy and many other medical services and supplies that are not covered by hospital insurance. Part B also covers some preventive services.

   - Premiums for Part B come out of your Social Security check monthly
   - The standard premium for Part B is $115.40 for 2011.
   - If your income is higher than $85,000 (single) you may pay more for Part B
   - After the deductible ($162 for 2011) is met, you typically pay 20% of the Medicare-approved amount of the service. For mental health services, you typically pay 50% after deductible.

Common Part B covered services include, <u>but are not limited</u> to the following:

-Ambulance Service

-Ambulatory Surgical Centers

-Bone Density Studies

-Cardiac Rehabilitation

-Cardiovascular Screenings

-Chiropractic Services

-Clinical Laboratory Services

-Colorectal Cancer Screenings

-Diabetes Self-Management training

-Doctor Services

-Durable Medical Equipment

- Emergency Department Services

-Flu Shots

-Home Health Services

-Mammograms (screening)

-Mental Health Care (outpatient)

-Pap Tests and Pelvic Exams

-Physical Exams (annually)

-Physical Therapy

-Prostate Cancer Screenings

-Prosthetic/Orthotic Items

-Pulmonary Rehabilitation

-Smoking Cessation counseling

-Speech-Language Pathology Services.

-Telehealth

-Tests including x-rays, MRIs, CT scans, EKGs and some others

-Transplants and Immunosuppressive Drugs

- A one-time "Welcome to Medicare" Physical Exam.

Some of the items and services that Medicare <u>doesn't</u> cover include, but are not limited, to the following:

□Long-term care □ Private Duty Nursing □Vision, Dental or Hearing

□Acupuncture □Blood, first three pints □Foreign Travel Emergency

□Medicare Part A or B Deductibles, Coinsurance or Copayments

- Coinsurance, hospital costs up to an additional 365 days after Medicare benefits exhausted

- Part A Hospice Care Coinsurance or Copayment

- Medicare Part B Excess Charges

3. **Medicare Advantage (Part C)** plans are available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C.

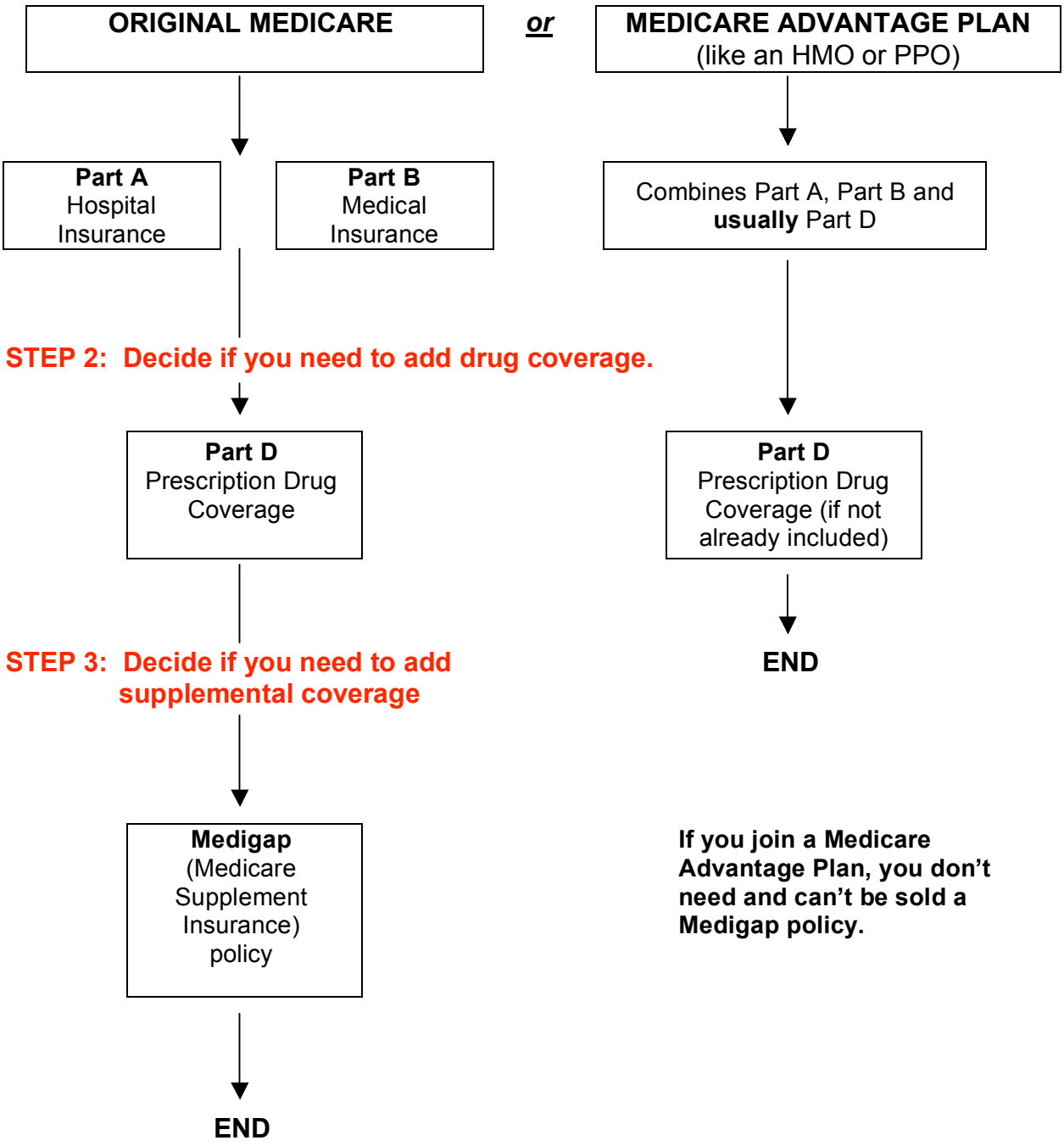
   This coverage is provided by commercial insurance companies and often includes Prescription Drug coverage and other additional coverage. Medicare Advantage Plans will be discussed in another section of this manual.

4. **Prescription drug coverage (Part D)** helps pay for medications that doctors prescribe for treatment. This type of coverage is covered in another section of this manual.

You can get more detailed information about what Medicare covers from *Medicare & You* (Publication No. CMS-10050). To get a copy, call the Medicare toll-free number, **1-800-MEDICARE** (**1-800-633-4227**), or go to ***www.medicare.gov***. If you are deaf or hard of hearing, you may call TTY **1-877-486-2048**.

The chart below was adapted from the 2011 publication *Medicare & You* and describes the two main ways to get your Medicare coverage. Using these steps will help you make your decision.

STEP 1: Decide how you want to get your coverage.



MEDICARE SUPPLEMENTAL PRODUCTS

Background

Medicare Parts A and B cover about 80% of the cost of hospital, physician, and other costs (not including outpatient Rx Drugs). The 20% that Medicare Parts A and B do not cover could cost Medicare Beneficiaries thousands of dollars. It is for this reason that many Medicare Beneficiaries purchase Medicare Supplemental products. Medicare supplemental products are designed to cover the gaps in Medicare Part A and B coverage. They are, therefore, also referred to as "Medigap" products. Medicare Supplemental products are standardized by the National Association of Insurance Commissioners (NAIC) and reviewed by the Federal Centers for Medicare and Medicaid Services (CMS). "Standardization means that all Individual Medicare Supplemental benefit programs are ***exactly the same***, regardless of what Insurance Company or Blue Cross Blue Shield program offers the product. Unlike Medicare Advantage products, Individual Medicare Supplemental Medicare Supplemental programs are administered and underwritten by Insurance Companies and Blue Cross Blue Shield Plans, rather than the Federal Government. Insurance Companies and Blue Cross Blue Shield Plans that offer Medicare Supplemental Products are regulated by the State Insurance Commissioner in the States where they offer their products.

Medicare Supplemental or similar products may also be offered on a group basis, through collective bargaining agreements, unions, and employers. These programs vary widely and are not uniform. ***Individua*****l** ***Medicare Supplemental products also do not cover prescription drugs. Prescription drugs are covered under Medicare Part D Prescription Drug Program, which must be purchased separately, for those Medicare beneficiaries who desire prescription drug coverage*** (See Medicare Part D Rx Drug section).

Medicare Supplemental topics discussed below include the following:

- What Medicare doesn't cover
- Medicare Supplemental Plan Descriptions
- Strong Points for Medicare Supplemental Products
- Things to watch out for with Medicare Supplemental Products
- Medicare Supplemental Enrollment and Administration

What Medicare doesn't cover

Medicare provides very comprehensive care but there are some health care expenses that Medicare does not cover. Examples of these items and areas include

- Non-approved experimental procedures
- First three pints of blood
- Private duty nursing

- Routine Vision and Dental
- Hearing aids
- Medical or hospital care outside of the U.S.
- Long Term Care

Medicare Supplemental products don't cover the above expenses, with the exception of emergency health care expenses outside of the U.S. and the first three pints of blood

In addition, there are some health care expenses that Medicare does cover, but not in full. Examples of these expenses include:

- The deductible for Hospital confinements less than or equal to 60 days. ($1,132 in 2011)
- The co-payment for the 61st to 90th day of a continuous hospital confinement ($283 a day in 2011)
- The co-payment from the 91st to the 150th day of a continuous hospital confinement ($565 a day in 2011). **NOTE** – there are only 60 lifetime reserve days to cover the 91st to the 150th day of a continuous hospital confinement. If the reserve days are already used up, the Medicare Beneficiary is responsible for 100% of the hospital costs.
- 100% of a continuous hospital confinement greater than 150 days.
- The Skilled Nursing Facility for the 21st to 150th day ($141.50 in 2011)
- 100% of the Skilled Nursing Facility costs beyond 150 days.
- The Medicare Part B deductible for doctors services, outpatient hospital charges, etc. (See Medicare section) ($162 in 2011)
- The 20% co-insurance for Medicare Part B expenses (See Medicare Section).

From the Medicare Beneficiary risk point, the most significant financial risks from the list above are:

- the cost of long and/or multiple hospital confinements;
- long stays in a Skilled Nursing Facility; and
- 20% of Medicare Part B expenses.

Medicare Supplemental Products are designed to cover some or all of above gaps in coverage. The effectiveness of Medicare Supplemental Products can be determined by how much of the significant financial risks are covered.

Medicare Supplemental Plan Descriptions

The chart below is taken from the 2011 "Choosing a Medigap Policy" booklet, developed by the Centers for Medicare and Medicaid Services (CMS).

Medigap Plans

How to read the chart:

If an "X" appears in a column of this chart, the Medigap policy coves 100% of the described benefit. If a row lists a percentage, the policy covers that percentage of the described benefit. If a row is blank, the policy doesn't cover that benefit. **Note:** The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

	MEDIGAP PLANS									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X***
Blood (First 3 Pints)	X	X	X	X	X	X	50%	75%	X	X
Part A Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	X	50%	75%	X	X
Medicare Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B Deductible			X		X					
Medicare Part B Excess Charges					X	X				
Foreign Travel Emergency (Up to Plan Limits)			X	X	X	X			X	X
							Out-of-Pocket Limit**			
							$4,645	$2,320		

*Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of $2,000 in 2011 before your Medigap plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible ($162 in 2011), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $2 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

Strong Points for Medicare Supplemental Products

Medicare Supplemental Products have many strong points as follows:

- Medicare Supplemental Products are accepted by any hospital, doctor, or other health care provider that accepts Medicare, throughout the country. This provides the maximum choice and flexibility.
- There are a wide range of Medicare Supplemental Products with different levels of coverage and premiums.
- The richer Medicare Supplemental Products, such as Plan F, pay for almost all of Medicare covered expenses.
- Medicare Supplemental products are standardized across the country.

Things to watch out for with Medicare Supplemental products

Things to watch out for with Medicare Supplemental products are as follows:

- Some Medicare Supplemental Product premiums are on an “attained age” basis, which means that the premiums will automatically increase as you age.
- Unless you enroll in Medicare Supplemental product when you become eligible for Medicare and/or for other special circumstances (see chart), you could be subject to medical underwriting if you want to join a Medicare Supplemental Plan.
- Medicare Supplemental Plans, unlike many Medicare Advantage Plans, do not include Medicare Part D Rx Drug Plans, which must be purchased separately.

MEDICARE ADVANTAGE

Background

Medicare Advantage (MA) products, sometimes referred to as "Medicare Part C", or MA programs, are Federal Government Plans that can be purchased by Medicare Beneficiaries ***in place of*** Original Medicare. Since the Medicare Advantage Plan is a Federal Government Program, these products are closely regulated by the Center for Medicare and Medicaid Services (CMS), the agency that administers the Medicare program. The Medicare approved programs are sold by commercial insurance companies, Blue Cross Blue Shield Plans and managed care organizations (HMOs). ***Medicare Advantage products have hospital and physician networks and are usually Preferred Provider Organizations (PPOs) or Health Maintenance Organizations (HMOs).*** Unlike Medicare Supplemental products, MA plans have a wide variety of benefits. Most MA products also include prescription drug coverage. Medicare Advantage products can also be offered on an Individual or Group Basis. The information below more typically describes Individual Medicare Advantage programs.

Medicare Advantage topics to be discussed below include the following:

- Medicare Advantage Health Maintenance Organizations (HMOs) and Point of Service (POS) products
- Medicare Advantage Preferred Provider Organizations (PPOs)
- Strong points of Medicare Advantage Products
- Things to watch out for in Medicare Advantage Products
- Medicare Advantage Enrollment and Administration

Medicare Advantage HMOs and Point of Service products

As stated above, Medicare Advantage products are primarily HMO or PPO products. Another variation is called a Point of Service Product (POS), which is basically an HMO product that allows members to use services outside of the HMO network, but at a reduced benefit level. Although there are wide variations in the Medicare Advantage products, some common product features are as follows:

- They are usually the lowest cost Medicare Advantage products.
- Primary Care Physicians such as family doctors, internists, pediatricians, etc., and OB-Gynecologist providers serve as "Gatekeepers" who coordinate care among specialists and other health care providers for each member.
- Typically a member must have a referral from their Primary Care Physician to see specialists and other health care providers.

- There is greater emphasis on preventative care and regular doctor visits.
- The network of hospitals and doctors is usually smaller than other products such as PPOs.
- HMO benefits are not payable if non-network hospitals, doctors or other health care providers are used.
- Lesser benefits are provided if non-network hospitals, doctors, or other health care providers are used in Point of Service products.
- Participating Medicare Advantage HMO hospitals, doctors, and other health care providers must accept HMO patients unless their practice is filled to capacity and, they cannot bill patients for more than the negotiated HMO prices.
- Doctors, hospitals, and other health care providers are more closely managed than other products.
- Benefits are comprehensive and usually include Medicare Part D Prescription Drug coverage (see Medicare Part D Prescription Drug Section).
- Most costs are usually covered with co-payments for physician visits and certain services such as emergency room and outpatient services.

Medicare Advantage Preferred Provider Organizations (PPOs)

- These plans are usually more expensive than HMOs but less expensive than Medicare Supplemental products.
- These plans usually do not require using a primary care physician as a gatekeeper.
- These plans have larger networks than Medicare Advantage HMOs, but not as large as the network of all participating Medicare providers in most areas.
- Lesser benefits are provided if non-network hospitals, doctors, and other health care providers are used.
- Participating Medicare Advantage PPO hospitals, doctors, and other health care providers must accept PPO patients unless their practices are filled to capacity. They also cannot bill patients for more than the PPO negotiated prices.
- Doctors, hospitals, and other health care providers have some management rules and programs, but less than Medicare Advantage HMOs.
- Benefits are comprehensive and usually include Medicare Part D Prescription Drug coverage (See Medicare Part D Prescription Drug Section).
- Most charges are usually covered; however, the patient is responsible for co-payments and/or deductibles for physician office visits, and certain services such as emergency rooms and outpatient hospital services. Typically, these costs are more than Medicare Advantage HMOs.

Strong Points for Medicare Advantage Products

In general, some of the strongest points of Medicare Advantage products are as follows:

- *Lower Cost* – Medicare Advantage products are typically, but not always, less expensive than Medicare Supplemental products.
- *All Inclusive* – All benefits are in one package. Medicare Advantage plans usually include Medicare prescription drug programs, in addition to Medicare Part A and Part B benefits.
- *Extra Benefits* – Sometimes these plans include benefits not covered by Medicare such as limited dental, vision, and hearing.
- *Contracted Network Hospitals and Doctors* – Members have assurance that hospitals and doctors will accept them, as well as follow network rules, such as no balance billing. This is important in parts of the country where doctors do not always accept Medicare.
- *Community Rated* – All Medicare Advantage products are community rated. This means that premiums will not automatically increase due to your age, and cannot increase for an individual who has high health care expenses, although premium rates could increase for the community members as a whole.
- *Case Mix Adjustment* – Since Medicare Advantage programs are Medicare programs, the Federal Government pays Medicare Advantage programs more if their populations have more health issues than normal. This adjustment helps to hold down Medicare Advantage premiums.

Things to watch out for in Medicare Advantage Products

In general some of the concerns for Medicare Advantage products are as follows:

- *Reduction in Federal Medicare Advantage Payments* – The Federal Government spends more for each Medicare Advantage beneficiary than for each Original Medicare beneficiary. In part, this is one of the reasons that Medicare Advantage programs are generally less expensive. Reductions in Medicare Advantage payments have often been cited as a way to help fund Health Care Reform. These extra payments to insurance companies reduce the cost of the Medicare Advantage product. On the other hand, there are many States where large portions of the Medicare population belong to Medicare Advantage products, making the phasing out of Medicare Advantage programs politically difficult. Government actions concerning higher beneficiary premiums for Medicare Advantage programs should be closely watched.
- *Hospital and Physician Networks* – Medicare Advantage Hospital and Physician Networks tend to be smaller than the total of the Participating Medicare Networks, which are used by Medicare Supplemental Products in most areas of the country. It

is very important to make sure that the hospitals and doctors that you want to use participate in the Medicare Advantage Network.

- *Availability of Specialists and Hospitals outside of the service area* – Medicare Advantage Programs often have no out-of-network coverage for hospitals and physicians outside of their service areas. A Medicare Advantage member may not be able to use a nationally known specialist or clinical trial that is in another state. Out-of-area benefits vary widely and must be examined carefully.
- *Prescription Drug Programs* – Like all Part D programs, it is always important to find out if the prescription drugs a member needs are covered under the Medicare Advantage Prescription Drug Plan. If the prescription drug(s) is covered, it is important to find how much of the cost is covered. (See the section on Medicare Part D Prescription Drug coverage to identify your costs).
- *Copayments, co-insurance and deductibles* – Medicare Advantage programs typically have copays and deductibles. A higher level Medicare Supplemental program such as Plan F has no deductibles. (See Medicare Supplemental Section). The trade-off between premium cost and benefits needs to be carefully analyzed.

Medicare Special Needs Plans

Medicare Special Needs Plans are Medicare Advantage Plans specifically designed for Medicare Beneficiaries

1) who are eligible for Medicaid and Medicare (Dual Eligible's);
2) who have specific chronic diseases such as diabetes and congestive heart failure;
3) who live in institutions like nursing homes or require nursing care at home.

There are many rules and specific requirements for Medicare Special Needs Plans. Some highlights of Special Needs Plans are as follows:

- Medicare Special Needs Plans, like other Medicare Advantage Plans, are Federal Government Plans which are administered by private insurance companies and other organizations.
- There are different levels of Medicaid assistance provided by State Medicaid programs. The level of State assistance will determine a beneficiary's eligibility for Special Needs programs.
- Eligibility for Medicaid is usually determined by both income and assets.
- A Medicare Beneficiary's Medicaid card is always needed to establish eligibility for Dual Eligible Special Needs Plans.
- Dual Eligible Special Needs Plans usually are "zero" premium for the Medicare Beneficiary.
- Dual Eligible Special Needs Plans usually provide extra benefits such as transportation to health providers, dental, and vision benefits.

- Chronic Disease Special Needs programs are usually focused on one chronic disease in a specified geographical location.
- Chronic Disease Special Needs programs are usually based on a strong integrated network of health care providers that manage all phases of the chronic disease.
- Chronic Disease Medicare Beneficiaries must be willing to use network doctors, hospitals, and other health care providers.
- Chronic Disease Special Needs Plans usually are “zero” premium for the Medicare Beneficiary.

Conclusion

Medicare Advantage Programs can be a good option for many Medicare beneficiaries. The benefits and other features vary widely throughout the country. Comparing Medicare Advantage and Medicare Supplemental programs can be confusing. Remember, Double Health USA agents are certified to discuss all the options with you and can help you choose the best plan for your needs.

PRESCRIPTION DRUG COVERAGE

MEDICARE PART D

Medicare Part D is the voluntary, stand-alone prescription drug program designed for use with Original Medicare plans*.

Things to Consider with Medicare Part D Prescription Drug Programs

- Penalty – If you don't sign up for a Medicare Part D Prescription Drug Program during your initial enrollment period and you do not have proof of other creditable drug coverage, you will pay a penalty when you finally decide to enroll in a prescription drug program. A one percent penalty multiplied by the beneficiary premium that was effective during your initial eligibility period is applied to each month that passes after the initial enrollment period. (**EXAMPLE**: 2011 Part D National Base Beneficiary Premium = $32.34 X .01= .3234 X 12 months = approximately $3.88/month added to current premium rate. This example assumes you only wait 12 months before enrolling; if you wait 24 months, the approximate additional monthly premium would be $7.76). The penalty amount will always be applied to the current Part D National Base Beneficiary premium rate.

- Formularies – This will determine ***if*** a prescription is covered, as well as ***what level*** a prescription drug is covered. Formularies can change, so you need to check every year to make sure the prescription drugs you use are still covered. A formulary will also determine what ***Benefit Tier*** a specific prescription drug falls into. For example, a specific prescription drug may be considered a "Preferred Brand" drug or a "Non-Preferred Brand" drug. Typically, the "Non-Preferred Brand" will have a significantly higher copayment that you would have to pay.

- Benefits for Part D Prescription Drug Programs vary – For example, some prescription drug plans have deductibles which could increase your out-of-pocket costs.

- Use the Medicare.gov Prescription Drug Plan Finder – The Prescription Drug Plan Finder is a tool provided by the Federal Center for Medicare and Medicaid Services. There are a wide variety of plans, and they vary in the cost of each drug and the specific drugs covered. The best way to check your specific set of medications is to take the following steps:

    1. Make a listing of your drugs, dosage and frequency. We have included an example for you at the end of this section.

People who choose a Medicare Advantage Plan (MA-PD) will have drug coverage included.

2. Go to the website Medicare.gov/find a plan and enter in each of your prescription medications and follow the instructions on the website. This website will ask for your zip code, and will then customize a listing of drug plans available that serve your area along with the cost of each plan.

3. Choose the best plan that covers your drugs at the highest benefit level possible and the most affordable fee (premium payment).

4. It is often helpful to talk to an insurance professional on these complex rules. A toll-free number has been set up with Double Health USA. Call 866-600-7083 to speak with an agent.

Coverage Gap ("The Donut Hole")

The Medicare Prescription Drug Coverage Plan pays for approximately 75% of the cost of your prescriptions. Most plans require that you pay a yearly deductible before the insurance applies. Also, you will pay a copayment/coinsurance as part of each purchase.

Most Medicare drug plans have a coverage gap (donut hole). This means after you and your drug plan have spent a certain amount of money ($2,840 for 2011) for covered drugs, you have to pay ALL costs for your prescriptions up to a yearly limit ($4,550 for 2011). About 22-26% of Part D beneficiaries reach the donut hole. Your yearly deductible, your coinsurance/copayments and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan premium you pay or what you pay for drugs that are not covered. Once you reach the limit, the Part D program pays most of the cost.

The following chart gives an example of drug payments when someone enters the coverage gap:

Monthly Premium ---- Mr. Smith pays a monthly premium throughout the year			
1. Yearly Deductible	2. Copayment or Coinsurance (Your portion of each transaction at the pharmacy)	3. Coverage Gap	4. Catastrophic Coverage
Mr. Smith pays the first $310 of his drug costs before his plan starts to pay its share.	Mr. Smith pays a copayment and his plan pays its share for each covered drug until their **combined** amount (plus the deductible) reaches $2,840	Once Mr. Smith and his plan have spent $2,840 for covered drugs, he is in the coverage gap. In 2011 there is a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps him get out of the coverage gap.	Once Mr. Smith has spent $4,550 out-of-pocket for the year, his coverage gap ends. For the rest of the year, there will only be a small copayment for each drug.

The above chart is adapted from the ***Medicare & You 2011*** booklet distributed by the Centers for Medicare and Medicaid Services, and is an excellent resource for more information on the Medicare Part D program.

SAMPLE MEDICATION LISTING

Mr. John Smith (diabetic, heart disease, depression)

Medications	*Dosage*	*Frequency*	*Test Results*	*Physician*	*Notes*
Heart Medications					
Altace	10mg	1/day-pm		Dr. Mike Brown, M.D. 12345 Main Street Your Town, Fla. Phone No.	Cardiologist visit twice yearly
Metoprol ER Succinate	50mg	1/day-pm			
Lipitor	40mg	1/day-pm			
Diabetic Medications					
Metformin	1000 mg	am & pm		Dr. Yolanda Smith 12345 Main Street Our Town, Fla. Phone no.	HbAlC test every six months Take meds with meal
Januvia	100 mg	1/day			
Glimepride	4 mg	1.5/day			
Actos	45mg	1/day am			
Other Medications					
Testin 1% gel	0.5mg	1/day			Gel to be applied on skin..wash hands after using
Effexor XR	75 mg	1/day-am		Dr. Sigmund Freud	Take together for combined dose of 225 mg.
Effexor XR	150mg	1/day-am			
Over the Counter Medications					
Aspirin	82 mg	daily			
Vitamins	Muliti + D + B12	Each- 1/day			Take with largest meal of the day

Enrollment Periods and Administration

Medicare and Medicare Advantage programs have the same enrollment periods. Medicare Advantage programs also have special rules for dropping Medicare Advantage programs and joining Medicare Advantage or Medicare Plans.

Your **Initial Enrollment Period** begins when you first become eligible for Medicare. This is a seven-month period that begins three months before the month you turn age 65, including the month you turn age 65, and ends three months after the month you turn age 65.

Every year, you have a chance to make changes to your **Medicare Advantage or Medicare prescription drug coverage** for the following year. There are two separate enrollment periods each year.

The first of these open enrollment periods in **2011** for Medicare Advantage and Medicare prescription drug coverage is from **October 15 through December 7**. During this time, you can:

- Change from Original Medicare to a Medicare Advantage Plan
- Change from a Medicare Advantage Plan back to Original Medicare
- Switch from one Medicare Advantage Plan to another Medicare Advantage Plan
- Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage
- Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
- Join a Medicare Prescription Drug Plan
- Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan
- Drop your Medicare prescription drug coverage completely

The next open enrollment period will occur from **January 1 through February 14**. During this time, you have the following options:

- If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare.
- If you switch to Original Medicare during this period, you will have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form.

During this period, you **cannot**:

- Switch from Original Medicare to a Medicare Advantage Plan
- Switch from one Medicare Advantage Plan to another
- Switch from one Medicare Prescription Drug Plan to another
- Join, switch, or drop a Medicare Medical Saving Account Plan

Medicare Rights and Protections

Consumer protection rights and protections are in place for Original Medicare, Medicare Advantage Plans or other Medicare health plans, and Medicare drug plans. These are all detailed in the Centers for Medicare & Medicaid Services official government booklet, "**Your Medicare Rights and Protections".**

Highlights of the rights and protections for all Medicare recipients from this booklet states that *"All people with Medicare have certain guaranteed rights and protections, including the right to the following:*

- *Be treated with dignity and respect at all times*
- *Be protected from discrimination*
- *Get understandable information about Medicare to help you make health care decisions, including:*
  - *What is covered*
  - *How much Medicare pays*
  - *How much you have to pay*
  - *What to do if you want to file a complaint or an appeal"*

Highlights of your rights and appeals in Original Medicare states that you have the right to "See any doctor or specialist (including women's health specialists), or go to any Medicare-certified hospital that participates in Medicare; Get certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care; a fair, efficient, and timely process for appealing health care payment decisions; and to buy a Medigap policy".

The above applies to a Medicare Advantage Plan or other Medicare Health Plan, but includes the right to *"Choose health care providers within the plan so you can get the health care you need; get a treatment plan from your doctor; and know how your doctors are paid".*

Additionally, if you are enrolled in a Medicare drug plan, *"you have the right to a fair, efficient, and timely coverage determination and appeals process to resolve differences with your plan; file a complaint (called a 'grievance') with the plan; and have the privacy of your health and prescription drug information protected".*

Other Retiree Cost Risks

Whether you have Original Medicare, a Medicare Supplemental program, or a Medicare Advantage program, most of the costs of health care are covered. However, there are some **non-medical expenses** that are typically not covered by any of these products.

Recently, the private insurance market has seen the emergence of a variety of insurance products that help cover the "gaps" in costs caused by the rising expenses of health care. These products typically help with those "hidden" or unexpected costs associated with health care such as transportation services and long hospitalizations, not fully covered by Medicare, Medicare Supplemental, and/or Medicare Advantage products. These costs are often not anticipated by the consumer and could surprise retirees on a fixed income. They do not replace health care insurance, and are not comprehensive but are designed to help offset ancillary costs and gaps in coverage.

Some of these policies include:

- Accident -- Usually provides a specific sum when a consumer is injured in an accident.
- Disease Specific – Provides benefits directly to consumer if he/she gets certain diseases to help offset gaps in health care coverage and covers ancillary costs such as transportation.
- Hospital Confinement Indemnity – If a consumer is confined to a hospital or a rehabilitation unit, it provides a specified benefit amount.
- Specified Health Event -- Usually pays a "first occurrence" hospital confinement and continuing care for conditions such as heart attack, stroke, end-stage renal failure, major organ transplant, major third degree burns, coma and paralysis.
- Hospital Intensive Care -- Provides a benefit if consumer is confined to intensive care to help offset gaps in coverage/co-insurance/deductibles for this high cost.

Benefits for **ALL** of these types of policies are paid **DIRECTLY** to the consumer, to help offset the gaps of expenses associated with health care. They do not pay directly to the provider, and are not meant to replace health care coverage, but rather to **SUPPLEMENT** such coverage.

In addition, stand-alone products for dental and vision are also available.

Things to consider for Other Cost Risks and Insurance

- Retirees should decide whether they want to insure these risks or "self-insure" these risks by saving for them.
- Hospitalizations are relatively unpredictable.
- Dental and Vision expenses are relatively predictable.
- The premiums for these products should be weighed against the financial risks that they pose to retirees.