



Module 1C: Understanding Medicare



*...helping people with Medicare
make informed health care decisions*

National Medicare Training Program Workbook

Module 1C: Understanding Medicare



This module, Understanding Medicare, contains basic information about the Medicare program. It is divided into four lessons.

NOTE TO INSTRUCTORS: This module is suitable for presenting to groups of people with Medicare, as well as partners, trainers, and other information intermediaries. The various lessons can be included and/or adapted based on the audience and time limits for the presentation.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The information in this module was correct as of April 2009. To check for an updated version of this training module, visit www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp on the web.

Slides with this symbol in your workbook may not be included in the presentation, but are provided as a resource for more detail.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

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SLIDE 2 *Speaker's Notes*

Let's look at the five lessons we'll cover in this training session.

In Lesson 1 we'll provide a brief overview of the Medicare program including eligibility and enrollment.

In Lesson 2 we'll review the benefits provided under Part A and Part B, and discuss the different ways people can get Medicare.

Lesson 3 will explore Medicare Advantage Plans and other Medicare plans. *[If the Instructor plans to present Module 11, Medicare Advantage Plans and Other Medicare Plans, he or she may wish to skip most of this lesson.]*

Lesson 4 is an overview of Medicare prescription drug coverage. *[If the Instructor plans to present Module 9, Understanding Prescription Drug Coverage, he or she may wish to skip most of this lesson.]*

Lesson 5 takes a brief look at some programs that are available to help you pay your health care expenses if you have limited income and resources.

Lessons

1. Program Basics
2. Original Medicare (Part A and Part B)
3. Medicare Advantage Plans (Part C) and other Medicare plans
4. Medicare prescription drug coverage (Part D)
5. Programs for people with limited income and resources

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SLIDE 3

Lesson 1

Program Basics

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SLIDE 4 *Speaker's Notes*

Let's look at the topics we'll cover in Lesson 1.

We will start with a brief overview of the Medicare program, what is Medicare, the options people with Medicare have on how they receive their health care services, who is eligible, and how to apply for Medicare.

Program Basics *Lesson 1 Topics*

- What is Medicare
- Options
- Who is eligible
- How to apply

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SLIDE 5 *Speaker's Notes*

Medicare is health insurance for people:

- Age 65 and older
- Under age 65 with certain disabilities (who have been receiving Social Security disability benefits for a certain amount of time—24 months in most cases). The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig's Disease). People with ALS get Medicare the first month they are entitled to disability benefits. This provision became effective on July 1, 2001.
- Of any age who have End-Stage Renal Disease (ESRD; permanent kidney failure requiring dialysis or a transplant)

President Lyndon Johnson signed the Medicare and Medicaid programs into law July 30, 1965. Medicaid became effective January 1, 1966, and Medicare became effective July 1, 1966. Medicare is the nation's largest health insurance program, currently covering about 44 million Americans.

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

Medicare

- Health insurance for people
 - Age 65 and older
 - Under age 65 with certain disabilities
 - Any age with End-Stage Renal Disease (ESRD)
- Administered by
 - Centers for Medicare & Medicaid Services (CMS)
- Enroll through
 - Social Security or
 - Railroad Retirement Board (RRB)

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SLIDE 6 *Speaker's Notes*

Medicare covers many types of services, and people have options for how they can get their Medicare coverage.

- Medicare has Part A, which is hospital coverage
- Part B, which is medical coverage
- Part C, private insurance plans that provide Medicare coverage, such as Health Maintenance Organizations (HMO) and Preferred Provider Organization (PPO)
- Part D, which covers outpatient prescription drugs.

Medicare gives you choices in how you get your health and prescription drug coverage. Medicare plan options are discussed in more detail in Lesson 2.

Medicare

- Medicare has
 - Part A – Hospital insurance
 - Part B – Medical insurance
 - Part C – Medicare Advantage Plans
 - Part D – Prescription drug coverage
- You have choices in how you get your Medicare health and drug coverage

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SLIDE 7 *Speaker's Notes*

Original Medicare is one of the choices in the Medicare program. You will be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare plan. Original Medicare is a fee-for-service program that is managed by the Federal Government.

When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care. If you have Medicare Part A, you get all the Part A-covered services, and if you have Medicare Part B, you get all the Part B-covered services. As we mentioned earlier, Part A (hospital insurance) is premium-free for most people. For Medicare Part B (medical insurance) you pay a monthly premium (\$96.40 in 2009 for most people). With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.

In Original Medicare, you also pay deductibles and coinsurance or copayments. After you receive health care services, you get a letter in the mail showing what was covered, called a Medicare Summary Notice (MSN). This notice lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There is information on the MSN about how to ask for an appeal.

Original Medicare

- Red, white, and blue Medicare card
- Part A and/or Part B
- Go to any provider that accepts Medicare
- You pay
 - Part B premium
 - Part A free for most people
 - Deductibles
 - Coinsurance or copayments

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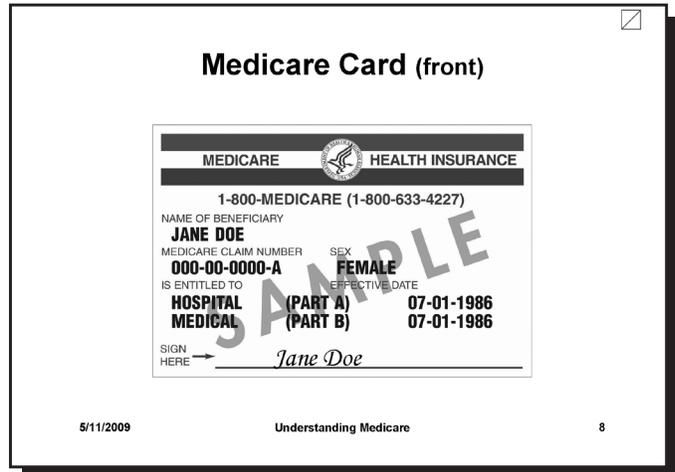
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SLIDE 8 Speaker's Notes

This slide shows a sample of a red, white, and blue Medicare card. The Medicare card shows the Medicare coverage (Part A hospital coverage and/or Part B medical coverage) and the date the coverage starts.

NOTE: Your card may look slightly different from this one; it's still valid.



The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you are related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a "B" or a "D." For railroad retirees, there are numbers and letters in front of the Social Security number. These letters and numbers have nothing to do with having Medicare Part A or Part B.

Your use of the Medicare card will differ depending on the type of Medicare health plan option you choose. If you choose Original Medicare, you will use the red, white, and blue Medicare card when obtaining health care. If you choose another Medicare health plan, your plan may give you a card to use when you get health care services and supplies. If any information on the card is incorrect, you should contact the Social Security Administration (SSA), or the Railroad Retirement Board if you receive railroad retirement benefits.

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SLIDE 9 *Speaker's Notes*

SSA advises people to apply for Medicare benefits 3 months before age 65. If you meet all the requirements, SSA will enroll you in Medicare starting the first day of the month you become age 65. You don't have to be retired to enroll in Medicare. Except for people with certain disabilities or ESRD, Medicare benefits can begin no earlier than the month you turn 65.*

If you are already receiving Social Security benefits, you will be automatically enrolled in Medicare without an additional application. You will receive a welcome to Medicare package, which includes your Medicare card and other information about 3 months before age 65 or your 25th month of disability benefits.

NOTE: People with ALS—Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease—automatically get Part A the month their disability benefits begin.

If you are not already getting benefits, you should call SSA at 1-800-772-1213 three months before your 65th birthday, even if you plan to continue working. (TTY users should call 1-800-325-0778.)

If you have railroad employment, call the Railroad Retirement Board (RRB) at 1-877-772-5772 or your local RRB office.

*If your birthday falls on the first day of a month, you are eligible for Medicare beginning the first day of the previous month.

Applying for Medicare

- Apply 3 months before age 65
 - Need not be retired
- Automatically enrolled if receiving Social Security or Railroad Retirement benefits
 - If not receiving benefits, apply 3 months before age 65
 - Call SSA at 1-800-772-1213
 - TTY users call 1-800-325-0778
 - If you have railroad employment
 - Call RRB at 1-877-772-5772

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SLIDE 10 *Speaker's Notes*

Let's look at the topics we'll cover in Lesson 2.

During this lesson we will learn about applying for Medicare Part A and B and associated premiums. We will go over the benefits covered under Part A and Part B and your cost for the actual services. Then we'll cover, what it means when a doctor accepts "assignment," private contracts, and what Medigap, or Medicare Supplement Insurance, is and how it works.

Medicare Part A & B

Lesson 2 Topics

- Applying for Medicare Part A and Part B
- Paying Part A & B premiums
- Covered services and cost
- Assignment and private contract
- Medigap (Medicare Supplement Insurance)

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SLIDE 11

Lesson 2

**Medicare Part A
Hospital Insurance**

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SLIDE 12

Speaker's Notes

Most people don't have to pay a monthly payment (premium) for Medicare Part A because they or their spouse paid Medicare or FICA taxes while they were working. (FICA stands for Federal Insurance Contributions Act. It's the tax withheld from your pay-check, or that you pay based on your self-employment income, that funds the Social Security and Medicare programs.)

Medicare Part A

- Part A premium is free for most people
- People with less than 10 years of Medicare-covered employment
 - Can pay a premium to get Part A
- For information, call SSA
 - 1-800-772-1213
 - TTY users call 1-800-325-0778

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If you or your spouse did not pay Medicare taxes while you were working, or if you or your spouse did not work long enough (10 years in most cases) in Medicare-covered employment to qualify for premium-free Medicare Part A, you may still be able to get Medicare Part A. However, you will have to pay a monthly premium. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.

If you worked for less than 7½ years in Medicare-covered employment, you will pay a higher premium than if you worked between 7½ years and 10 years in Medicare-covered employment. SSA will determine if you have to pay a premium for Part A.

For 2009, the premium amounts are \$443 per month for those who have not worked at least 7½ years, and \$244 per month for those who have worked at least 7½ years but not as long as 10 years.

If you don't buy Part A when you are first eligible, the monthly premium may go up 10% for each year you were eligible for Part A, but didn't join. You will have to pay the higher penalty for 2 years. This penalty won't apply to you if you are eligible for a special enrollment period.

For information on Medicare Part A entitlement, enrollment, or premiums, call SSA at 1-800-772-1213. TTY users should call 1-800-325-0778.

Notes:

SLIDE 13 *Speaker's Notes*

Medicare Part A, hospital insurance, helps pay for

- Hospital inpatient care
- Skilled nursing facility (SNF) care (not custodial or long-term care)
- Some home health care
- Hospice care
- Blood

Part A Coverage

- Hospital inpatient care
- Skilled nursing facility (SNF) care
- Home health care
- Hospice care
- Blood

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For more information about Part A coverage and services, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

NOTE: Part A may also help cover inpatient care in a Religious Non-medical Health Care Institution (RNHCI), which is a facility that provides non-medical health care to people for whom the acceptance of medical services would be inconsistent with their religious beliefs.

Section 1821 of the Social Security Act provides for coverage of services furnished in a Medicare qualified RNHCI, when the beneficiary meets specific coverage conditions. The beneficiary must have a valid election for RNHCI services and would otherwise qualify for care in a conventional hospital or post hospital extended care facility that was not an RNHCI.

The RNHCI benefit provides only for Part A inpatient services. The program does not pay for supporting religious services or payment for the religious practitioner. The cost of religious items/services and the cost of using a religious practitioner is a personal financial responsibility and not covered by Medicare.

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SLIDE 14 *Speaker's Notes*

A benefit period refers to the way Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you are admitted to a hospital as an inpatient. The benefit period ends when you have not received Medicare-reimbursed hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible (\$1,068 in 2009) for each benefit period.

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

Medicare Part A

- Charges based on "benefit period"
 - Inpatient hospital care and SNF services
 - Begins day admitted to hospital
 - Ends when no care received in a hospital or SNF for 60 days in a row
 - You pay deductible for each benefit period
 - No limit to number of benefit periods

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Notes:

SLIDE 15 *Speaker's Notes*

Covered services for hospital inpatients include the following:

- Semi-private room
- Meals
- General nursing
- Other hospital services and supplies

Inpatient Hospital Stays

- Covered services
 - Semi-private room
 - Meals
 - General nursing
 - Other hospital services and supplies
- Includes care in critical access hospitals
- 190-day limit for inpatient mental health care in a lifetime

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This includes inpatient care you get in acute care hospitals, in critical access hospitals (small facilities that give limited services to people in rural areas), inpatient rehabilitation facilities, long term care hospitals, as part of a clinical research study and mental health care.

Inpatient mental health care coverage in an independent psychiatric hospital is limited to 190 days in a lifetime

Coverage does not include:

- Private duty nursing
- Television or telephone in your room if there are separate charges for these items
- Private room unless medically necessary

Notes:

SLIDE 16 *Speaker's Notes*

For inpatient hospital stays in 2009 you pay:

- A total of \$1,068 for days 1 – 60 each benefit period (the hospital deductible)
- \$267 co-payment per day for days 61 – 90 each benefit period
- \$534 co-payment per day for days 91 – 150 of a hospital stay

Paying for Hospital Stays

- For inpatient Hospital stays in 2009 you pay
 - \$1,068 total deductible for days 1 – 60
 - \$267 co-payment per day for days 61 – 90
 - \$534 co-payment per day for days 91 – 150 (60 lifetime reserve days)
 - All costs for each day beyond 150 days

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Original Medicare will pay for a total of 60 extra days—called “lifetime reserve days”—when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don’t get any more **extra** days during your lifetime.

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SLIDE 17 *Speaker's Notes*

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

- Your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a skilled nursing facility. This does not include custodial or long-term care
- You were an inpatient in a hospital 3 consecutive days or longer, not counting the day you leave the hospital, before you were admitted to a participating SNF
- You were admitted to the SNF within 30 days after leaving the hospital
- Your care in the SNF is for a condition that was treated in the hospital
- The facility **MUST** be a Medicare participating SNF

Skilled Nursing Facility Care

- Conditions of coverage
 - Require daily skilled services
 - Not long-term or custodial care
 - After at least 3 consecutive days of inpatient hospital care for a related illness or injury
 - Admitted to SNF within 30 days of hospital discharge
 - **MUST** be a Medicare participating SNF

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SLIDE 18 *Speaker's Notes*

If you qualify, Medicare will cover the following SNF services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications, and medical supplies/equipment used in the facility
- Ambulance transportation, when other transportation endangers health, to the nearest supplier of needed services that are not available at the SNF
- Dietary counseling

Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation
- Dietary counseling

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SLIDE 19 *Speaker's Notes*

Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. Under Original Medicare, for days 21 – 100, SNF care is covered except for coinsurance of up to \$133.50 per day in 2009. After 100 days, Medicare Part A no longer covers SNF care.

Paying for Skilled Nursing Facility Care

- For each benefit period in 2009 you pay
 - \$0 for days 1–20:
 - \$133.50 per day for days 21–100
 - All costs after 100 days
- Must meet requirements for Medicare-covered stay
 - Does NOT include custodial care
 - If it is the only care you need

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You can qualify for skilled nursing care again every time you have a new benefit period.

Keep in mind that skilled nursing care is different from nursing home care. Most nursing home care is custodial or non-skilled care, such as help with dressing, bathing, eating, or other activities of daily living, which are not covered by Medicare if that is the only care you need. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.

Notes:

SLIDE 20 *Speaker's Notes*

Medicare Part A pays for your home health services for as long as you are eligible and your doctor says you need these services. (Part B also may pay for home health care under certain conditions.) However, there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services.

Home Health Care

- For as long as you are eligible
 - Limited hours per day
 - Limited days per week
- Four conditions
 - Doctor must make a plan for your care at home
 - Must need specific skilled services
 - Must be homebound
 - Home health agency must be Medicare-approved

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To be eligible, you must meet four conditions:

1. Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
2. You must need at least one of the following services: intermittent (not full-time) skilled nursing care, physical therapy, speech language pathology services, or continue to need occupational therapy.
3. You must be homebound, which means that you are normally unable to leave home or that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care (may include adult day care) or attend a religious service.
4. The home health agency caring for you must be approved by Medicare.

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SLIDE 21 *Speaker's Notes*

Home health care is limited to reasonable and necessary part-time or intermittent skilled care or continuing need for physical therapy, occupational therapy, or speech-language pathology ordered by the doctor and provided by a Medicare-certified home health agency.

Home health services may also include:

- Medical social services
- Home health aide services or other services
- Durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers)
- Medical supplies for use at home

Home Health Care

- Covered services
 - Part-time/intermittent skilled nursing care
 - Therapy
 - Physical
 - Occupational
 - Speech-language
 - Medical social services
 - Some home health aide services
 - Durable medical equipment, supplies

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Notes:

SLIDE 22 *Speaker's Notes*

If you qualify, home health care is fully covered by Medicare for each 60-day period that you need care (called an episode of care). Your doctor and home health agency staff review your plan of care at least once every 60 days. You will continue to get home health care for as long as you are eligible.

In Original Medicare, you pay:

- Nothing for covered home health care services provided by a Medicare-approved home health agency
- 20% of the Medicare-approved amount for an assigned durable medical equipment claim. If the claim is non-assigned, the person with Medicare is responsible for whatever the durable medical equipment supplier charges over and above the Medicare-approved amount. (We will discuss **assignment** in just a few minutes.)

If you have questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. To find a home health agency in your area, call 1-800-MEDICARE or visit www.medicare.gov and use the Home Health Compare tool.

Paying for Home Health Care

- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of the Medicare-approved amount for covered durable medical equipment

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SLIDE 23 *Speaker's Notes*

Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than 6 months to live if the disease runs its normal course. Care is given in "periods of care"—two 90-day periods followed by unlimited 60-day periods.

At the start of each period of care, your doctor must certify that you are terminally ill for you to continue getting hospice care. Medicare must approve the hospice care provider.

Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care as well as inpatient respite care when needed, which we will discuss on the next slide.

The Medicare Modernization Act authorizes CMS to conduct a Hospice Demonstration project, to test the benefits of providing hospice services in a hospice facility to people in rural areas who are unable to receive hospice care at home for lack of an appropriate caregiver.

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

Hospice

- Special care for terminally ill and family
 - Expected to live 6 months or less
- Focuses on comfort, not on curing the illness
- Doctor must certify for each "period of care"
 - Two 90-day periods
 - Unlimited 60-day periods
- Hospice provider must be Medicare-approved

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SLIDE 24 *Speaker's Notes*

The hospice benefit covers many services that are out of the ordinary. In addition to the regular Medicare-covered services such as doctor and nursing care, physical and occupational therapy, and speech therapy, the hospice benefit also covers:

- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control and pain relief
- Short-term care in the hospital when needed for pain and symptom management
- Inpatient respite care, which is care given to a hospice patient by another caregiver, so the usual caregiver can rest. You will be cared for in a Medicare-approved facility, such as a hospice residential facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there is no limit to the number of times you can get respite care.
- Home health aide and homemaker services
- Social worker services
- Dietary counseling
- Counseling to help you and your family with grief and loss

Covered Hospice Services

- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care
- Respite care in a Medicare-certified facility
 - Up to 5 days each time
 - No limit to number of times
- Home health aide and homemaker services
- Social worker services
- Dietary counseling
- Grief counseling

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SLIDE 25 *Speaker's Notes*

For hospice care in Original Medicare, you pay a copayment of no more than \$5 for each prescription drug and other similar products for pain relief and symptom control and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of \$100 per day for inpatient respite care, you will pay \$5 per day. The amount you pay for respite care can change each year.

Room and board are generally not payable by Medicare except in certain cases. For example, room and board are not covered if you receive general hospice services while a resident of a nursing home or a hospital's residential facility. However, room and board are covered during short-term hospital stays and for inpatient respite care.

To find a hospice program, call 1-800-MEDICARE (1-800-633-4227) or your state hospice organization in the blue pages of your telephone book. TTY users should call 1-877-486-2048.

Paying for Hospice Care

- Payment in Original Medicare
 - You pay up to \$5 for prescription drugs
 - You pay 5% for inpatient respite care
 - Amount can change each year
- Room and board generally not payable

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Lesson 2

**Medicare Part B
Medical Insurance**

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SLIDE 27 *Speaker's Notes*

Enrolling in Part B (medical coverage) is your choice. You can sign up for Part B anytime during a 7-month period that begins 3 months before the month you turn age 65. This is called your Initial Enrollment Period (IEP). As we said earlier, if you are already receiving Social Security benefits, you will be automatically enrolled in Medicare without an additional application. This automatic enrollment includes Part A and Part B. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B.

Also, during this Initial Enrollment Period people can join a Medicare Advantage Plan, other Medicare plan, or a Medicare Prescription Drug Plan.

Enrolling in Medicare Part B

- Enrollment in Part B is your choice
- Initial Enrollment Period (IEP)
 - 7 months beginning 3 months before age 65
- Enrolled automatically if receiving Social Security
 - Includes Part A and Part B
 - To keep Part B, keep the card
 - If you don't want Part B, follow instructions with card

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SLIDE 28 *Speaker's Notes*

If you do not choose Part B when you are first eligible at age 65, you may sign up during a General Enrollment Period (GEP) (January 1 – March 31 of each year, with coverage effective July 1 of that year). However, the cost of Part B will go up 10% for each 12-month period that you could have had Part B but did not take it, except in special cases. In most cases, you will have to pay this penalty for as long as you have Part B.

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

- Any time you are still covered by the employer or union group health plan through your or your spouse's current or active employment OR
- During the 8 months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

Call SSA at 1-800-772-1213 if you have questions about the date to enroll or the amount of your premiums. TTY users should call 1-800-325-0778. If you will be getting benefits from the Railroad Retirement Board, call your local RRB office or 1-800-772-5772.

NOTE: People who have to pay for Part A can also sign up for Part A during their IEP, the GEP, or an SEP.

Enrolling in Medicare Part B

- General Enrollment Period (GEP)
 - January 1 through March 31 each year
 - Coverage effective July 1
 - Premium increases 10% for each 12-month period you were eligible but did not enroll
 - Pay this penalty as long as you have Part B
 - Limited exceptions
- Special Enrollment Period
 - Sign up within 8 months of the end of employer or union health plan coverage
 - No increased premium

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SLIDE 29 *Speaker's Notes*

People generally pay a monthly premium for Medicare Part B. For most people, the Part B premium is \$96.40 in 2009. If you can't afford to pay the Part B premium, there are programs that may help, which will be discussed later in this module.

Some people with higher annual incomes pay a higher Part B premium. These amounts can change each year. In 2009, if the modified adjusted gross income for an individual is:

- \$85,001 - \$107,000, the Part B premium is \$134.90 per month
- \$107,001 - \$160,000, the Part B premium is \$192.70 per month
- \$160,001 - \$213,000, the Part B premium is \$250.50 per month
- Greater than \$213,000, the Part B premium is \$308.30 per month

The income ranges for joint returns are double that of individual returns. Social Security uses the income reported on your most recent tax return to determine the Part B premium. For example, the income reported on a 2007 tax return filed in 2008 is used to determine the monthly Part B premium in 2009. Contact Social Security if you filed an amended return or your income has gone down. For more information about premiums based on income, call Social Security at 1-800-772-1213.

Remember that this premium may be higher if you did not choose Part B when you first became eligible. The cost of Medicare Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. An exception would be if you or your spouse is still employed and you are covered by a group health plan through that employment. In that case, you could delay enrolling in Part B without a penalty.

Paying the Part B Premium

- Most people pay \$96.40 monthly in 2009

If Your Yearly Income is		You pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	\$96.40
\$85,001-\$107,000	\$170,001-\$214,000	\$134.90
\$107,001-\$160,000	\$214,001-\$320,000	\$192.70
\$160,001-\$213,000	\$320,001-\$426,000	\$250.50
Above \$213,000	Above \$426,000	\$308.30

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Understanding Medicare

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Notes:

Module 1C: Understanding Medicare

SLIDE 30 *Speaker's Notes*

If you choose to have Medicare Part B, the premium is automatically taken out of your monthly Social Security or Railroad Retirement payment. If you are a Federal Government retiree, you may be able to have the premium deducted from your retirement check.

For information about your Medicare Part B premiums, call the agency that enrolled you in Medicare, or call the Office of Personnel Management if you are a retired Federal employee.

If you do not get any of the above payments, Medicare sends you a bill for your Medicare Part B premium every 3 months. You may pay your bill by credit card, check, or money order. You may also elect to have your Part B premium automatically deducted from your bank account using the Easy Pay option. (You may also use Easy Pay if you pay a premium for Part A.) You can contact 1-800-MEDICARE (1-800-633-4227) and request a Medicare Easy Pay Authorization Form. TTY users should call 1-877-486-2048.

Paying the Medicare Part B Premium

- Taken out of your monthly payment
 - Social Security
 - Railroad Retirement
 - Federal Government retirement
- For information about premiums
 - Call SSA or RRB
 - OPM if a retired Federal employee
- May be billed every 3 months
- Medicare Easy Pay
- Programs available to help

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Understanding Medicare

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Notes:

SLIDE 31 *Speaker's Notes*

We have just reviewed the services covered by Medicare Part A. Now let's talk about Part B.

Medicare Part B helps pay for doctors' services, outpatient hospital care, medical supplies, and some other medical services that Medicare Part A does not cover, such as the services of physical, occupational, and speech therapists in an outpatient setting, and some home health care. Part B also covers outpatient mental health care.

Part B Coverage

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic tests
- Outpatient therapy
- Outpatient mental health services
- Some preventive health care services
- Other medical services

5/11/2009

Understanding Medicare

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Notes:

Module 1C: Understanding Medicare

SLIDE 32 *Speaker's Notes*

Other services covered by Medicare Part B include, but are not limited to, the following:

- Clinical laboratory services (blood tests, urinalysis, and more)
- Home health services (part-time skilled care, home health aide services)
- Durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services
- Outpatient hospital services for the diagnosis or treatment of an illness or injury
- Blood (pints of blood needed as an outpatient or as part of a medical service covered by Medicare Part B, after the first 3 pints)
- Ambulance service, when other transportation would endanger your health. (For more information on coverage, payment, and rights and protection issues related to ambulance services, get a copy of *Medicare Coverage of Ambulance Services*, CMS Pub. No. 11021, by visiting www.medicare.gov on the web.)

Original Medicare doesn't cover everything. Items and services that **aren't** covered include, but aren't limited to:

- Acupuncture
- Dental care and dentures (with only a few exceptions)
- Cosmetic surgery
- Health care while traveling outside the U.S. (except in limited cases)
- Hearing aids
- Eye care (routine exam), eye refractions, and most eyeglasses
- Long-term care, such as custodial care in a nursing home

Part B Coverage

- Clinical laboratory tests
- Home health services
- Durable medical equipment
- Outpatient hospital services
- Blood
- Ambulance service
 - If other transportation would endanger your health

5/11/2009

Understanding Medicare

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Notes:

SLIDE 33 *Speaker's Notes*

Medicare Part B also covers preventive services like exams, lab tests, screening and shots to help prevent, find, or manage a medical problem. Preventive services may find health problems early when treatment works best. Talk to your doctor about which preventive services you need and if you meet the criteria for coverage. The *Medicare & You* handbook includes guidelines for who is covered and how often Medicare will pay for these services. Currently Medicare helps pay for:

- “Welcome to Medicare” physical exam (one-time review of your health, as well as education and counseling about the preventive services you need. To be covered, you must have the physical exam within the first 12 months you have Medicare Part B.)
- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- Screening mammograms
- Pap test and pelvic exam (includes clinical breast examination)
- Prostate cancer screening
- Three kinds of vaccinations (shots)—for influenza, pneumococcal pneumonia, and Hepatitis B
- Smoking cessation (counseling to stop smoking)

These services are discussed in depth in MODULE 7.

Covered Preventive Services

- “Welcome to Medicare” physical exam
- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Flu shots
- Pneumococcal shots
- Hepatitis B shots
- Smoking cessation

5/11/2009

Understanding Medicare

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Notes:

SLIDE 34 *Speaker's Notes*

If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. For 2009, the amount is \$135. This means that you must pay the first \$135 of your Medicare-approved medical bills in 2009 before Medicare Part B starts to pay for your care. In addition, a person who needs blood must pay for the first three pints.

You also pay some copayments or coinsurance for Part B services. The amount depends upon the service, but is 20% in most cases.

If you can't afford to pay these costs, there are programs that may help, which will be discussed later in this module.

Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible
 - \$135 in 2009
 - 20% coinsurance for most services
 - Some copayments
- Some programs may help

5/11/2009

Understanding Medicare

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Notes:

SLIDE 35 *Speaker's Notes*

To understand Original Medicare, it is important to define the term "assignment." Assignment is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare. It is important to know that the assignment provision only applies to Medicare Part B claims.

Assignment

- Agreement between
 - People with Medicare
 - Doctors and other health care suppliers and
 - Medicare
- Applies to Original Medicare Part B Claims

5/11/2009

Understanding Medicare

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Notes:

SLIDE 36 *Speaker's Notes*

Doctors or providers who accept assignment from Medicare agree to be paid by Medicare and agree to get only the amount Medicare approves for their services. Providers who accept assignment can only charge people with Medicare, or any other insurance they have, the Medicare deductible and/or coinsurance amount.

Accepts Assignment

- Providers agree to
 - Be paid by Medicare
 - Get only the amount Medicare approves for their services
 - Only charge the Medicare deductible and/or coinsurance amount

5/11/2009

Understanding Medicare

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Notes:

SLIDE 37 *Speaker's Notes*

If a doctor, other health care supplier, or provider doesn't agree to accept assignment, he or she may charge you more than the Medicare-approved amount. For most services, there is a limit to how much over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and

other providers who don't accept assignment is called the **limiting charge**. The limiting charge is 15% over the Medicare-approved amount. The limiting charge applies only to certain services and doesn't apply to medical supplies and durable medical equipment.

In addition, you may have to pay the entire charge at the time of service. Medicare will send you its share of the charge when the claim is processed.

In some cases, your health care providers and suppliers must accept assignment. For example, if you get Medicare Part B-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare program, the pharmacy or supplier must accept assignment. Medicare-covered ambulance services must also be assigned claims.

CAUTION: If you get your Medicare Part B-covered prescription drugs or supplies from a supplier/pharmacy not enrolled in Medicare, you may have to file your own claim for Medicare to pay. Doctors and other providers generally have to submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service.

Does NOT Accept Assignment

- May charge more than Medicare-approved amount
 - Limit of 15% more for most services
 - Called "the limiting charge"
- May ask you to pay entire charge at time of service
- In some cases, providers must accept assignment
 - Some examples
 - Medicare Part B-covered prescription drugs
 - Ambulance providers

5/11/2009

Understanding Medicare

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Notes:

SLIDE 38 *Speaker's Notes*

A private contract is an agreement between you and a doctor who has decided not to give services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) will not pay for the services you get from the doctor with whom you have a private contract. You

cannot be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
- You will have to pay whatever this doctor or provider charges you. (The Medicare limiting charge will not apply.)
- Other Medicare plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- Many other insurance plans will not pay for the service either.
- The doctor cannot bill Medicare for any services for people with Medicare for 2 years.

Private Contracts

- Individual agreement between you and your doctor
 - Original Medicare will not pay
 - Medigap will not pay
 - Other Medicare plans will not pay
 - You will pay charges
 - No claim should be submitted
 - Cannot be asked to sign in an emergency

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Understanding Medicare

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Notes:

SLIDE 39 *Speaker's Notes*

Original Medicare pays for many health care services and supplies, but it doesn't pay all of your health care costs. There are costs that you must pay, like coinsurance, co-payments, and deductibles. These costs are sometimes called "gaps" in Medicare coverage. A Medigap policy is a health insurance policy sold by a private insurance company to fill the "gaps" in Original Medicare coverage. The companies must follow Federal and state laws that protect people with Medicare.

What Is Medigap?

- Health insurance policies
 - Sold by private insurance companies
 - Follow Federal and state laws that protect you
 - Must say "Medicare Supplement Insurance"
 - Cover "gaps" in Original Medicare
 - Sold as standardized policies, plans A – L
 - Except in Minnesota, Massachusetts, Wisconsin
 - Costs may vary by
 - Plan, company, where you live

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The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." In all states except Minnesota, Massachusetts, and Wisconsin, any new Medigap policy sold must be one of 12 standardized plans, A through L. The benefits in any Medigap Plan A through L are the same for any insurance company. For example, the benefits in one insurance company's Medigap Plan C are the same as any other insurance company's Medigap Plan C. **However, there can be big differences in the premiums different insurance companies charge for exactly the same coverage.** Insurance companies are not required to sell Medigap policies for all 12 plans.

NOTE: Some people may still have a Medigap policy they bought before Medigap policies were standardized.

When you buy a Medigap policy, you pay a **premium** to the Medigap insurance company. As long as you pay your Medigap premium, a policy bought after 1990 is automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium; we say your policy is **guaranteed renewable**. You still must pay your monthly Medicare Part B premium. In some states, insurance companies may legally refuse to renew Medigap policies that were bought before 1990.

Notes:

Module 1C: Understanding Medicare

SLIDE 40 *Speaker's Notes*

A Medigap policy only works with Original Medicare. Medigap policies won't work with Medicare Advantage Plans or other Medicare plans. In fact, it is illegal for anyone to sell you a Medigap policy if you:

- Are in a Medicare Advantage Plan (unless your enrollment is ending),
- Have Medicaid (unless Medicaid pays for your Medigap policy or only pays your Medicare Part B premium), or
- Already have a Medigap policy (unless you are canceling your old Medigap policy).

If you have a Medigap policy and you join a Medicare Advantage Plan or other Medicare plan, you may want to drop your Medigap policy. Even though you are entitled to keep it, it can't pay for benefits that you get under your Medicare Advantage Plan or other Medicare plan and can't pay any cost-sharing under these plans.

If you are in Original Medicare and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider that accepts Medicare. However, if you have a type of Medigap policy called **Medicare SELECT**, you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits.

For more detailed information on Medigap, see MODULE 3, Medigap, Medicare Supplemental Insurance.

How Medigap Works

- Only works with Original Medicare
 - Don't need Medigap if in MA Plan or other Medicare plans
- Can go to any doctor, hospital, or provider that accepts Medicare
 - Except with a Medicare SELECT policy
- You pay a monthly premium

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Understanding Medicare

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Notes:

SLIDE 41

Exercise

A. The Centers for Medicare & Medicaid Services is responsible for enrolling most people in Medicare.

1. True
2. False

Exercise

A. The Centers for Medicare & Medicaid Services is responsible for enrolling most people in Medicare.

1. True
2. False

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Understanding Medicare

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Notes:

SLIDE 42

Exercise

- B. For most people, the Part A premium is free.
1. True
 2. False

Exercise

- B. Most people receive Part A premium free.
1. True
 2. False

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Understanding Medicare

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Notes:

SLIDE 43

Exercise

- C. The Part B premium for most people is \$96.40 in 2009.
1. True
 2. False

Exercise

- C. The Part B premium for most people is \$96.40 in 2009.
1. True
 2. False

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Understanding Medicare

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Notes:

SLIDE 44 *Exercise*

D. "Assignment" is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare.

1. True
2. False

Exercise

D. "Assignment" is an agreement between people with Medicare, doctors and other health care suppliers or providers, and Medicare.

1. True
2. False

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Understanding Medicare

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Notes:

SLIDE 45

Exercise

- E. Providers who don't accept "assignment" may charge as much as they wish.
1. True
 2. False

Exercise

- E. Providers who don't accept "assignment" may charge as much as they wish.
1. True
 2. False

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Understanding Medicare

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Notes:

Module 1C: Understanding Medicare

SLIDE 46 *Exercise*

Discussion should include the following points:

Even though she is still working, Sandy and Eric's mother should enroll in Part A when she is first eligible, 3 months prior to turning 65. Remember most people don't have to pay a monthly payment (premium) for Medicare Part A because they or their spouse paid Medicare or FICA taxes while they were working.

Enrollment in Medicare Part B is optional. Since Sandy and Eric's mother is currently working and has a group health coverage through her employer, she can wait to sign up for Part B during a Special Enrollment Period. People who sign up for Part B during a Special Enrollment Period do not pay higher premiums. She can sign up:

- Any time she is still covered by the employer or union group health plan through her current or active employment **OR**
- During the 8 months following the month when the employer or union group health plan coverage ends, or when the employment ends (whichever is first)

You're the counselor...



Eric and Sandy are in your office. Their mother is about to turn 65 and she is planning to retire when she turns 67. She is working full-time and has health insurance through her current employer. They want to find out if she needs to enroll in Medicare now, and what are her options. Discuss the Medicare eligibility requirements and the enrollment periods.

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Understanding Medicare

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Notes:

SLIDE 47 *Exercise*

Discussion should include the following points:

- Medigap is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare, like co-insurance, copayments, and deductibles.
- Medigap policies are sold as standardized plans A through L in all states except Minnesota, Massachusetts, and Wisconsin. The standardized Medigap policies must provide the same benefits, e.g., a Medigap Plan A policy always provides the same benefits.
- When you buy a Medigap policy, you pay a **premium** to the Medigap insurance company, and you still must pay your monthly Medicare Part B premium. As long as you pay your Medigap premium, a policy bought after 1990 is automatically renewed each year.
- A Medigap policy only works with Original Medicare, not with a Medicare Advantage Plan or other Medicare plan.
- If you have Original Medicare and a Medigap policy, you can go to any doctor, hospital, or other health care provider that accepts Medicare. (This is true unless you have a Medicare SELECT policy, in which case you must use specific hospitals or doctors to get full benefits.)

You're the counselor...



David has called you to see if you can help him understand some information he received in the mail about a Medigap policy. He will be eligible for Medicare next month. Discuss what Medigap is and how it works.

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Understanding Medicare

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Notes:

Module 1C: Understanding Medicare

SLIDE 48 *Speaker's Notes*

NOTE TO INSTRUCTOR: If you plan to present Module 11 Medicare Advantage Plans, you may wish to skip most of this lesson.

Lesson 3

Medicare Advantage Plans

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Notes:

SLIDE 49 *Speaker's Notes*

During this lesson we will cover:

- What are Medicare Advantage Plans and other Medicare plans
- Who can join these plans
- Opportunities to join and switch plans
- How the plans work
- Your out-of-pocket costs

Medicare Advantage Plans *Lesson 3 Topics*

- What are Medicare Advantage Plans and other Medicare plans
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket costs

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For more detailed information, see MODULE 11, Medicare Advantage Plans and Other Health Plans.

NOTE: In this lesson, when we use the term “Medicare Advantage Plans,” we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not include Original Medicare or stand-alone Medicare Prescription Drug Plans.)

Notes:

SLIDE 50 *Speaker's Notes*

Medicare Advantage Plans are health plan options that are approved by Medicare and run by private companies. They are another way to get your Medicare benefits through private companies approved by Medicare. They are part of the Medicare program, and are sometimes called "Part C."

Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members' health care.

If you join a Medicare Advantage Plan, you are still in Medicare and get all the Medicare-approved Part A and B benefits. The costs may be different, and you may get extra benefits not covered by Original Medicare.

What Are Medicare Advantage Plans?

- Health plan options approved by Medicare
 - A way to get your Medicare benefits through private companies approved by Medicare
- Run by private companies
- Part of the Medicare program
 - Sometimes called "Part C"

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Understanding Medicare

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Notes:

SLIDE 51 *Speaker's Notes*

There are five main types of Medicare Advantage Plans:

- **Medicare Health Maintenance**

Organizations (HMO) Plans—managed care plans that cover all Part A and B services and may provide extra services. You can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.

- **Medicare Preferred Provider Organization (PPO) Plans**—similar to an HMO plan, but members can see any doctor or provider that accepts Medicare, and they don't need a referral to see a specialist. Going to a provider that isn't part of the plan's network will usually cost more.
- **Medicare Special Needs Plans (SNP)**—membership is limited to certain groups of people, such as those in certain institutions (like a nursing home), those eligible for both Medicare and Medicaid, or those with certain chronic or disabling conditions.
- **Medicare Private Fee-for-Service (PFFS) Plans**—members can go to any provider that accepts the plan's terms, and may get extra benefits. The private company decides how much it will pay and how much members pay for services.
- **Medicare Medical Savings Account (MSA) Plans**—similar to Health Savings Account plans available outside of Medicare, and they have two parts.
 - The first part is a Medicare Advantage Health Plan with a high deductible. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan.
 - The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

Medicare Advantage Plans

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plan (SNP)
- Medicare Medical Savings Account (MSA)

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Understanding Medicare

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Notes:

SLIDE 52 *Speaker's Notes*

There are three other types of other Medicare health plans:

- **Medicare Cost Plans**—similar to an HMO, but services received outside the plan are covered under Original Medicare
- **Demonstrations and pilot programs**—special projects that test possible future improvements in Medicare coverage, costs, and quality of care,
- **PACE (Programs of All-inclusive Care for the Elderly)**—combines medical, social, and long-term care services for frail elderly people, those who are eligible for both Medicare and Medicaid.

Other Medicare Plans ☑

- Medicare Cost Plans
- Demonstrations/Pilot Programs
- Programs of All-inclusive Care for the Elderly (PACE)

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Notes:

SLIDE 53 *Speaker's Notes*

Medicare Advantage Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, you must:

- Live in the plan's geographic service area or continuation area
- Have Medicare Part A and Part B
- Not have End-Stage Renal Disease (ESRD). People with ESRD usually can't join a Medicare Advantage Plan or other Medicare plan. However, there are some exceptions.

In addition, you must:

- Agree to provide the necessary information to the plan
- Agree to follow the plan's rules
- Belong to only one plan at a time

To find out what Medicare Advantage Plans are available in your area, visit www.medicare.gov and choose the link *Compare Health Plans and Medigap Policies in Your Area* to use the Medicare Options Compare tool, or call 1-800-MEDICARE (1-800-633-4227).

Who Can Join?

- Eligibility requirements
 - Live in plan service area
 - Have Medicare Part A
 - Have Medicare Part B
 - Not have ESRD at time of enrollment
 - Some exceptions

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Notes:

SLIDE 54 *Speaker's Notes*

People can join a Medicare Advantage Plan when they first become eligible for Medicare, i.e., during their Initial Coverage Election Period, which begins 3 months immediately before their first entitlement to both Medicare Part A and Part B, or at any time a plan is allowing new members to join, which may be during the Annual Election Period, the annual Medicare Advantage Open Enrollment Period, and in certain special situations that provide a Special Enrollment Period.

People can only join one Medicare Advantage Plan at a time, and enrollment in a plan is generally for a calendar year.

When Can You Join?

- You can join a Medicare Advantage Plan or other Medicare plan
 - When first eligible for Medicare
 - Initial Coverage Election Period
 - During specific enrollment periods
 - Annual Coordinated Election Period
 - Medicare Advantage Open Enrollment Period
 - Special Enrollment Periods

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Notes:

SLIDE 55 *Speaker's Notes*

A person can switch to another Medicare Advantage Plan or to Original Medicare:

- During the Annual Election Period from November 15 – December 31.
- During the Medicare Advantage Open Enrollment Period from January 1 – March 31.
- Under special circumstances that grant a Special Enrollment Period. For example, if a person moves out of the plan's service area, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

When Can You Switch?

- Annual Election Period
- Medicare Advantage Open Enrollment Period
- Special Enrollment Periods
 - Move from the plan service area and cannot stay in the plan
 - Plan leaves Medicare program
 - Other special situations

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Notes:

SLIDE 56 *Speaker's Notes*

Let's talk more about how Medicare Advantage Plans work.

In most Medicare Advantage Plans, you generally get all your Medicare-covered health care through that plan. Some plans also include Medicare prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals. Benefits and cost-sharing in a Medicare Advantage Plan may be different than in Original Medicare.

How MA Plans Work

- Get Medicare-covered services through the plan
- Can include prescription drug coverage
- May have to see certain doctors or go to certain hospitals to get care
- Benefits and cost-sharing may be different than in Original Medicare

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Understanding Medicare

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Notes:

SLIDE 57 *Speaker's Notes*

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

- You must continue to pay the monthly Medicare Part B premium (\$96.40 in 2009 for most people). However, some Medicare Advantage Plans may offer an additional benefit by reducing the amount members pay for their Medicare Part B premiums.
- You may pay an additional monthly premium to the plan.
- You will have to pay other costs (such as copayments or coinsurance) for the services you get.

Out-of-Pocket Costs

- Generally must still pay Part B premium
 - Some plans may pay all or part
- May pay additional monthly premium
- Pay other out-of-pocket costs
 - Different from Original Medicare
 - Vary from plan to plan

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Understanding Medicare

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Notes:

SLIDE 58 *Speaker's Notes*

It's also important to note that if you join a Medicare Advantage Plan, you:

- Are still in the Medicare program
- Still have Medicare rights and protections
- Still get all your regular Medicare-covered services offered under Part A and Part B
- May get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care, and/or health and wellness programs.

In a Medicare Advantage Plan

- Still in Medicare program
- Still have Medicare rights and protections
- Still get regular Medicare-covered services
- May get extra benefits
 - Such as vision, hearing, or dental care
- May be able to get prescription drug coverage

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Understanding Medicare

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Notes:

SLIDE 59

Exercise

A. Medicare Advantage Plans are sometimes called Part D.

1. True
2. False

Exercise

A. Medicare Advantage plans are sometimes called Medicare Part D.

1. True
2. False

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Notes:

SLIDE 60 *Exercise*

B. PACE stands for Programs of All-inclusive Care for the Elderly.

1. True
2. False

Exercise

B. PACE stands for Programs of All-Inclusive Care for the Elderly.

1. True
2. False

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Understanding Medicare

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Notes:

SLIDE 61

Exercise

- C. The Medicare Advantage Open Enrollment Period is from November 1 through January 15 each year.
1. True
 2. False

Exercise

C. The Medicare Advantage Open Enrollment Period is from November 1 through January 15 each year.

1. True
2. False

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Notes:

SLIDE 62

Exercise

D. Special Needs Plans may limit enrollment to certain groups of people with Medicare.

1. True
2. False

Exercise

D. Special Needs Plans may limit enrollment to certain groups of people with Medicare.

1. True
2. False

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Understanding Medicare

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Notes:

SLIDE 63

Exercise

- E. You can join a Medicare Advantage Plan at any time during the year.
1. True
 2. False

Exercise

E. You can join a Medicare Advantage Plan at any time during the year.

1. True
2. False

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Notes:

Module 1C: Understanding Medicare

SLIDE 64 *Exercise*

Discussion should include the fact that Margaret and Elizabeth get a Special Enrollment Period that allows them to join a different Medicare Advantage Plan or switch to Original Medicare. If they switch to Original Medicare, they can also choose to get Medigap policies.

You're the counselor...



You are meeting with Margaret and Elizabeth, two sisters who are in a Medicare HMO. They have decided to sell their home and move to a warmer climate. Their HMO does not offer service where they will be living. Discuss some of their options.

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Understanding Medicare

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Notes:

SLIDE 65 *Speaker's Notes*

NOTE TO INSTRUCTOR: If you plan to present Module 9 Understanding Prescription Drug Coverage, you may wish to skip most of this lesson.

Lesson 4

**Medicare Prescription
Drug Coverage**

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Notes:

Module 1C: Understanding Medicare

SLIDE 66 *Speaker's Notes*

The topics we'll discuss in this lesson include:

- What is a Medicare Prescription Drug Plan
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket cost
- Extra help

Medicare Prescription Drug Coverage *Lesson 4 Topics*

- What is a Medicare Prescription Drug Plan
- Who can join
- How to join and switch
- How plans work
- Your out-of-pocket cost
- Extra help

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Understanding Medicare

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Notes:

SLIDE 67 *Speaker's Notes*

Everyone with Medicare can join a Medicare prescription drug plan to help lower prescription drug costs and help protect against higher costs in the future.

CMS contracts with private companies offering prescription drug plans to negotiate discounted prices on behalf of their enrollees. People with Medicare can also receive drug benefits through a Medicare Advantage Plan or other Medicare plan if they are enrolled in one. (Some employers and unions may also provide Medicare drug coverage to people with Medicare.)

Prescription Drug Coverage

- Available for all people with Medicare
- Provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage Plans
 - Other Medicare plans

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Understanding Medicare

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Notes:

SLIDE 68 *Speaker's Notes*

Anyone who has Medicare Part A (hospital insurance) and/or Part B (medical insurance) is eligible to join a Medicare prescription drug plan. You must live in the service area of a plan to enroll in it.

In most cases, you must enroll in a Medicare drug plan to get Medicare prescription drug coverage.

Individuals who live outside of the U.S. or who are incarcerated cannot enroll in a Medicare drug plan.

Who Can Join

- You must
 - Have Medicare Part A, Part B, or both
 - Live in plan service area
 - Enroll in a Medicare prescription drug plan

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Understanding Medicare

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Notes:

SLIDE 69 *Speaker's Notes*

People can join a Medicare Prescription Drug Plan when they first become eligible for Medicare, i.e., during their Initial Coverage Election Period, which begins 3 months immediately before their first entitlement to both Medicare Part A and Part B.

People in Medicare can also enroll in a Medicare Prescription Drug Plan during the Annual Coordinated Election Period, which runs from November 15 — December 31 each year, and during a Special Enrollment Period, which we will discuss on the next slide.

In most cases, you must fill out an application and enroll with a plan to get coverage. However, if people who are found eligible for the extra help do not choose a plan on their own, CMS will usually enroll them in one.

When Can You Join?

- When first eligible for Medicare
 - 7 months beginning 3 months before first month of Medicare eligibility
- During specific enrollment periods
 - Annual Coordinated Election Period
 - November 15 – December 31 each year
 - Special Enrollment Periods
- Some people are enrolled automatically

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Notes:

SLIDE 70 *Speaker's Notes*

After you enroll in a Medicare Prescription Drug Plan you must remain with that plan for the rest of the calendar year.

You can change Medicare Prescription Drug Plans during your Annual Coordinated Election Period, or you must be eligible for a Special Enrollment Period.

When Can You Switch?

- Annual Election Period
- Special Enrollment Periods
 - Permanently move out of plan service area
 - Lose creditable prescription drug coverage
 - Enter, reside in, or leave a long-term care facility
 - Like a nursing home
 - Qualify for the extra help
 - Have other exceptional circumstances

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In certain situations, you may get a Special Enrollment Period. These include:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you were not adequately informed that your other coverage was not creditable or that the coverage was reduced so that it is no longer creditable
- When you enter, reside in, or leave a long-term care facility like a nursing home
- If you qualify for the extra help, you have a continuous Special Enrollment Period and can change your Medicare prescription drug plan at any time
- Or in exceptional circumstances, such as if you no longer qualify for the extra help

Notes:

SLIDE 71 *Speaker's Notes*

You can delay enrolling, but you may have to pay a higher monthly premium if you decide to enroll later (1% higher for each month you waited to join and did not have creditable prescription drug coverage). The penalty is added to the premium payment amount. It is calculated by multiplying 1% of the national base beneficiary premium (not the plan premium) by the number of months the person was eligible but not enrolled in a plan and did not have creditable drug coverage. The base beneficiary premium (\$30.36 in 2009) is a national number and can change each year.

NOTE: In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. The base beneficiary premium is different from the average beneficiary premium. The average member premium reflects the specific plan-by-plan premiums and the actual number of people who are enrolled in each plan.

People who have another source of drug coverage—through a former employer, for example—may choose to stay in that plan and not enroll in a Medicare prescription drug plan. If your other coverage is **at least as good as Medicare prescription drug coverage**, called “creditable” coverage, you will not have to pay a higher premium if you later join a Medicare prescription drug plan. Your other plan will notify you about whether or not your coverage is at least as good as Medicare’s. This notice will explain your options. You can contact your plan’s benefits administrator for more information.

Some examples of coverage that may be considered creditable include:

- Group Health Plans (GHP)
- State Pharmaceutical Assistance Programs (SPAP)
- VA coverage
- Military coverage including TRICARE
- Medigap (Medicare Supplement Insurance)

Late Enrollment Penalty

- People who wait to enroll after their IEP
 - Pay additional 1% of base beneficiary premium
 - For every month eligible and not enrolled
 - For as long as they have Medicare drug coverage
 - Except those with other creditable drug coverage
 - Coverage at least as good as Medicare prescription drug coverage

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Understanding Medicare

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Notes:

SLIDE 72 *Speaker's Notes*

Costs vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, which Original Medicare has set. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium. With every plan, once you have paid \$4,350 out of pocket for drugs costs in 2009, you will pay a small co-payment (around \$6) for each drug for the rest of the year.

People with limited income and resources may be able to get extra help paying for their Medicare drug plan costs.

Prescription Drug Costs

- Costs vary by plan
- Most people will pay
 - Monthly premium
 - Deductible
 - Copayments or coinsurance
 - Very little after \$4,350 out-of-pocket in 2009
- Extra help available for people with limited income and resources

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Understanding Medicare

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Notes:

SLIDE 73 *Speaker's Notes*

As we mentioned earlier, people with Medicare who have limited incomes and resources may be able to get extra help with the costs of Medicare prescription drug coverage. You must be enrolled in a Medicare prescription drug plan to get the extra help.

You can apply with either Social Security or your state's Medicaid program office. When you apply, you will be asked for information about your income and resources and you will be asked to sign a statement that your answers are true. Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.

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

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

- People with Medicare and full Medicaid benefits (including prescription drug coverage)
- People with Medicare who get Supplemental Security Income only (SSI)
- People who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs)

All other people with Medicare must file an application to get the extra help.

Extra Help

- Help with drug plan costs for people with limited income and resources
- Social Security or state makes determination
- Both income and resources are counted
- Some groups are automatically eligible
 - People with Medicare and
 - Medicaid
 - Supplemental Security Income (SSI) only
 - Medicare Savings Programs
 - Everyone else must apply

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Notes:

Module 1C: Understanding Medicare

SLIDE 74 *Speaker's Notes*

The extra help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources. (The poverty guidelines are generally published in late January or February for the current year.)

Let's talk about how income and resources are counted.

Medicare counts the income of you and your spouse living in the same household, regardless of whether or not your spouse is applying for the extra help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.

Resources also are counted for you and a spouse living with you. Only two types of resources are considered:

- Liquid resources (i.e., savings accounts, stocks, bonds, and other assets that could be cashed in within 20 days) and
- Real estate that does not include your home or the land on which your home is located.

Items such as wedding rings and family heirlooms are not considered resources for the purposes of qualifying for the extra help.

Contact the Social Security Administration at 1-800-772-1213 or your state Medical Assistance office for more information on the requirements and how to apply. To get the telephone number for your state Medical Assistance office, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Income and Resource Limits ☐

- **Income**
 - Below 150% Federal poverty level
 - 2009 amounts {
 - \$1,353.75 per month for an individual* or
 - \$1,821.25 per month for a married couple*
 - Based on family size
- **Resources**
 - 2009 amounts {
 - Up to \$12,510 (individual)
 - Up to \$25,010 (married couple)
 - Includes \$1,500/person funeral or burial expenses
 - Counts savings and stocks
 - Does not count home you live in

*Higher amounts for Alaska and Hawaii

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Notes:

SLIDE 75 *Speaker's Notes*

Eligibility for the extra help may be determined by either Social Security or your state Medicaid office.

You can apply for the extra help by:

- Completing a paper application that you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
- Applying with Social Security at **www.socialsecurity.gov** on the web
- Applying through your state Medical Assistance office
- Working with a local organization, such as your State Health Insurance Assistance Program (SHIP)

You can apply on your own behalf, or your application can be filed by a personal representative with the authority to act on your behalf, such as Power of Attorney, or you can ask someone else to help you apply.

How to Apply for Extra Help

- Multiple ways to apply
 - Paper application
 - www.socialsecurity.gov
 - State Medical Assistance office
 - Local organization
- You or someone on your behalf can apply

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Notes:

Module 1C: Understanding Medicare

SLIDE 76 *Exercise*

A. People who wait to enroll in a Part D plan after their Initial Enrollment Period may pay an additional 1% of the base beneficiary premium for every month they were eligible but not enrolled.

1. True
2. False

Exercise

- A. People who wait to enroll in a Part D plan after their Initial Enrollment Period may pay an additional 1% of the base beneficiary premium for every month they were eligible but not enrolled.
1. True
 2. False

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Notes:

SLIDE 77 *Exercise*

B. You must have Medicare Part A and Part B to enroll in a Medicare prescription drug plan.

1. True
2. False

Exercise

B. You must have Medicare Part A and Part B to enroll in a Medicare prescription drug plan.

1. True
2. False

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Understanding Medicare

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Notes:

SLIDE 78

Exercise

C. Certain groups of people automatically qualify for the extra help with Medicare prescription drug costs and do not have to apply.

1. True
2. False

Exercise

C. Certain groups of people automatically qualify for the extra help with Medicare prescription drug costs and do not have to apply.

1. True
2. False

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Notes:

SLIDE 79

Exercise

Discussion should include the following:

- Is Maria in one of the groups that automatically qualify for the extra help?
- Is she married and living with her husband? Does she have any dependents living with her?
- Does Maria (and her husband, if applicable) have limited income and resources? If yes, is her/their income below 150% of the Federal poverty level? Do her/their resources meet the limits?
- Does she have Medicare drug coverage now? Does she have any other drug coverage?
- If she could be eligible for the extra help and does not automatically qualify, Maria should contact Social Security or her state Medicaid office to apply. If she needs assistance, she can ask someone else to apply on her behalf.

You're the counselor...



Maria thinks she might qualify for extra help with Medicare prescription drug costs. She has called you to ask what she needs to do. Discuss how she should proceed.

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Notes:

SLIDE 80

Lesson 5

**Programs for People with
Limited Income and Resources**

5/11/2009 Understanding Medicare 80

Notes:

SLIDE 81 *Speaker's Notes*

In this lesson, we will cover:

- Medicaid
- Medicare Savings Programs, and
- Help available for people who live in the U.S. territories

Programs for People with Limited Income and Resources *Lesson 5 Topics*

- Medicaid
- Medicare Savings Programs (MSP)
- Help for people living in U.S. territories

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Understanding Medicare

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Notes:

SLIDE 82 *Speaker's Notes*

Medicaid is a program that helps pay medical costs for some people with limited income and resources. Medicaid is jointly funded by the Federal and state government and is administered by each state. It can cover children; aged, blind, and disabled people; and some other groups, depending on the state. If you are eligible for both Medicare and Medicaid, most of your health care costs are covered. People with both Medicare and Medicaid get drug coverage from Medicare, not Medicaid. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home care and home health care.

Medicaid eligibility is determined by each state, and Medicaid application processes and benefits vary from state to state. You need to contact your state Medical Assistance office to see if you qualify. For instance, a person in [Name of State], would apply for Medicaid at [Name of Agency].

INSTRUCTOR: Insert information specific to Medicaid in your state.

Medicaid

- Federal-state health insurance program
 - People with limited income and resources
 - Certain people with disabilities
- If eligible, most health care costs covered
- Eligibility determined by state
- Application processes and benefits vary
- Office names vary
 - Social Services
 - Public Assistance
 - Human Services

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Notes:

SLIDE 83 *Speaker's Notes*

States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid. These programs are collectively called Medicare Savings Programs, and include the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs.

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

Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.

Contact the State Health Insurance Assistance Program (SHIP) in your state to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Savings Programs

- Help from Medicaid paying Medicare premiums
 - For people with limited income and resources
 - May also pay Medicare deductibles and coinsurance
 - Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)

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Notes:

SLIDE 84 *Speaker's Notes*

There are also programs available to help people with limited income and resources who live in the U.S. territories—Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa—pay their Medicare costs. Programs vary in these areas. Contact the Medical Assistance office in the territory for more information.

Programs in U.S. Territories

- Help people pay their Medicare costs
- U.S. territories
 - Puerto Rico
 - Virgin Islands
 - Guam
 - Northern Mariana Islands
 - American Samoa
- Programs vary
 - Contact Medical Assistance office

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Notes:

SLIDE 85 *Speaker's Notes*

Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses.

First, review the income and resource (or asset) guidelines for your area. If you think you may qualify, collect the personal documents the agency requires for the application process. You will need:

- Medicare card
- Proof of identity
- Proof of residence
- Proof of any income, including pension checks, Social Security payments, etc.
- Recent bank statements
- Property deeds
- Insurance policies
- Financial statements for bonds or stocks
- Proof of funeral or burial policies

You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.

Finally, complete an application with your state Medical Assistance office.

Steps to Take

- If you think you might qualify
 1. Review guidelines
 2. Collect your personal documents
 3. Get more information
 - Call your state Medical Assistance office
 - Call your local SHIP
 - Call your local Area Agency on Aging
 4. Complete application with state Medical Assistance office

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Notes:

SLIDE 86

Exercise

A. Medicaid is a program that fills in the gaps in Original Medicare.

1. True
2. False

Exercise

A. Medicaid is a program that fills in the gaps in Original Medicare.

1. True
2. False

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Notes:

SLIDE 87

Exercise

B. Medicaid eligibility requirements are set by each CMS Regional Office.

1. True
2. False

Exercise

B. Medicaid eligibility requirements are set by each CMS Regional Office.

1. True
2. False

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Notes:

SLIDE 88

Exercise

C. The Medicaid application process is the same in every state.

1. True
2. False

Exercise

C. The Medicaid application process is the same in every state.

1. True
2. False

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Notes:

SLIDE 89

Exercise

D. The medical assistance program is the same for all U.S. territories.

1. True
2. False

Exercise

D. The medical assistance program is the same for all U.S. territories.

1. True
2. False

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Notes:

Module 1C: Understanding Medicare

SLIDE 90 *Exercise*

Discussion should cover:

- John and his son should bring John's Medicare card, address, income amounts, including pension checks, Social Security payments, etc., recent bank statements, property deeds, insurance policies, financial statements for bonds or stocks, proof of funeral or burial policies.
- When they come in to see you, describe the available programs, including the extra help with Medicare prescription drug costs (assuming John is entitled to Medicare).
- You could check the requirements for assistance in their state to see if John appears to qualify for any assistance with his medical bills.
- You could fill out the application(s) with them (if appropriate) or set up an appointment with the state Medical Assistance office, or refer them to the correct office, to apply for assistance.
- If John appears to qualify for the extra help, you could help him apply with Social Security using the online application.

You're the counselor...



John's son has called you to find out what help is available for his father. His father's medical costs have been high, and he is finding it hard to pay his bills. You schedule a meeting with the two of them. Discuss what you would ask them to bring and how you might be able to help them.

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Notes:

Module 1C: Understanding Medicare

SLIDE 91 *Speaker's Notes*

Let's look at the four lessons we covered in this training session.

After a brief overview of the Medicare program basics in Lesson 1, in Lesson 2 we reviewed the benefits provided under Parts A and B, how the program works and covered services. Lesson 3 explored Medicare Advantage Plans and other Medicare plans.

Lesson 4 was an overview of Medicare prescription drug coverage, and Lesson 5 took a brief look at some programs that are available to help you pay your health care expenses if you have limited income and resources.

A great deal of the information in this module comes directly from the *Medicare & You* handbook, which is a great resource for basic Medicare information. You can get a copy of the handbook by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Module 1 Lessons

1. Program Basics
2. Original Medicare (Part A and Part B)
3. Medicare Advantage Plans (Part C) and other Medicare plans
4. Medicare prescription drug coverage (Part D)
5. Programs for people with limited income and resources

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Notes:

Module 1C: Understanding Medicare

SLIDE 92 *Speaker's Notes*

You can get Medicare information through several key sources:

- 1-800-MEDICARE (1-800-633-4227), the official CMS helpline that is available 24 hours a day, 7 days a week
- The Medicare & You handbook, mailed each fall to all Medicare households
- Other CMS publications, available by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE
- The CMS website, www.cms.hhs.gov
- Your local State Health Insurance Assistance Program (SHIP). You can get your SHIP's telephone number by visiting www.medicare.gov, by calling 1-800-MEDICARE, or by looking in the *Medicare & You* handbook.

For More Information

- 1-800-MEDICARE (1-800-633-4227)
 - TTY users should call 1-877-486-2048
- *Medicare & You* handbook
- Other Medicare publications
- www.medicare.gov
- www.cms.hhs.gov
- Your local SHIP

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Notes:
