Senior Citizens Can Go to College for Free or Cheap in All 50 States

The Caucus Corner
The National Caucus and Center on Black Aging, Inc. (NCBA)
Bi-Monthly Newsletter
September/October 2019

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2019-2020 Medicare Open Enrollment

Every year a Medicare Open Enrollment Period, correctly referred to as the Annual Enrollment Period, is made available for people who qualify for Medicare benefits.

During this time, anyone who is eligible for Medicare Parts A and B can enroll in or make changes to their Medicare coverage. Medicare Part D Prescription Drug Coverage & Medicare Advantage benefits can change each year, meaning premiums can go up and benefits can change.

If you’re not happy with the changes to your current Part D or Medicare Advantage benefits and premiums, you have an Annual Election Period to change them. If you’re happy with your current plan and all the changes for next year, then there’s nothing you need to do!

2020 ANNUAL ENROLLMENT PERIOD DATES

Dates and deadlines you need to know

<table>
<thead>
<tr>
<th>DATE</th>
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<tr>
<td>OCT. 15, 2019</td>
<td>ANNUAL ENROLLMENT PERIOD BEGINS</td>
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<td>This is the first day you can enroll for 2020 health coverage.</td>
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<td>DEC. 7, 2019</td>
<td>ANNUAL ENROLLMENT PERIOD ENDS</td>
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<td>This is the last day you can enroll for 2020 health coverage.</td>
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<tr>
<td>JAN. 1, 2020</td>
<td>FIRST DATE COVERAGE CAN START</td>
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<td>Even if you enroll in December 2019, your new Medicare plan won’t go into effect until Jan. 1, 2020.</td>
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What are my Medicare coverage options?

Original Medicare

- Medicare provides this coverage directly.
- You have your choice of doctors, hospitals, and other providers that accept Medicare.
- If you want drug coverage, you must join a Medicare Prescription Drug Plan.
- You usually pay a monthly premium for Part D coverage.
- You may want to get coverage that fills the gaps in Medicare coverage. You can choose to buy a Medicare Supplement Insurance (Medigap) policy from a private company.

Medicare Advantage Plans (like HMOs or PPOs)

Includes all benefits and services covered under Part A and Part B:

- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Run by Medicare-approved private insurance companies that follow rules set by Medicare
- Plans have a yearly limit on your out-of-pocket costs for medical services
- May include extra benefits and services that aren’t covered by Original Medicare, sometimes for an extra cost

What’s Medicare?

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Skilled nursing facility care
- Hospice care
- Home health care

Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment
- Many preventive services

Part D (Medicare Prescription Drug Coverage):

- Helps cover the cost of prescription drugs
- Run by Medicare-approved drug plans that follow rules set by Medicare
- May help lower your prescription drug costs and help protect against higher costs in the future

What Are My Medicare Coverage Options?

Other Medicare health plans Some types of Medicare health plans that provide health care coverage aren’t Medicare Advantage Plans but are still part of Medicare.

- Examples of these plans include: Medicare Cost Plans, Program of All-inclusive Care for the Elderly (PACE), and Medicare Innovation Projects.
- These plans have some of the same rules as Medicare Advantage Plans.
- Each type of plan provides a different combination of coverage and has its own special rules and exceptions. Contact any plans you’re interested in to get more details.

Can I have other types of health coverage?

Yes. When you have other coverage (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. For more information on who pays first, visit Medicare.gov, or see your “Medicare & You” handbook.
If you have limited income and resources, you might qualify for Extra Help to pay for prescription drug costs. To get more information or apply for Extra Help, visit socialsecurity.gov/i1020.

Know Your Rights

No matter how you get your Medicare coverage, you have certain rights and protections. All people with Medicare have the right to:

- Be always treated with dignity and respect
- Be protected from discrimination
- Have their personal and health information kept private
- Get information in a way they understand from Medicare, health care providers, and Medicare contractors
- Have questions about Medicare answered
- Have access to doctors, other health care providers, specialists, and hospitals
- Learn about treatment choices in clear language that they can understand, and participate in treatment decisions
- Get Medicare-covered services in an emergency
- Get a decision about health care payment, coverage of services, or prescription drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called “grievances”), including complaints about the quality of their care

Protect yourself & Medicare from billing fraud Medicare fraud happens when Medicare is billed for services or supplies you never got. If you suspect fraud, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Where can I get more information? Visit Medicare.gov or call 1-800-MEDICARE. If you need help in a language other than English or Spanish, let the customer service representative know.

Preventive Services

Preventive services may prevent or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms). Medicare Part B covers preventive services like screening exams, yearly wellness visits, lab tests, and immunizations to help prevent, find, and manage medical problems.
These services are covered whether you get your coverage from Original Medicare, a Medicare Advantage (MA) Plan, or another type of Medicare health plan. However, the rules for how much you pay for these services may vary.

A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide Part A (Hospital Insurance) and Part B (Medical Insurance) (and sometimes Part D (Medicare prescription drug coverage)) benefits to people with Medicare who enroll in the plan. Medicare health plans include all MA Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Talk to your doctor about which preventive services you need, how often you need them to help you stay healthy, and if you meet the criteria for coverage based on your age, gender, and medical history.

**What’s Covered?**

- Abdominal Aortic Aneurysm Screening and Counseling
- Bone Mass Measurement (Bone Density)
- Breast Cancer Screening (Mammograms)
- Cardiovascular Disease Screenings
- Cervical and Vaginal Cancer Screenings
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training (DSMT)
- Flu Shots
- Glaucoma Test
- Hepatitis B Shots
- Hepatitis C Screening Test
- HIV (Human Immunodeficiency Virus) screening
- Lung Cancer Screening
- Medical Nutrition Therapy Services
- Medicare Diabetes Prevention Program
- Obesity Screening and Counseling
- Pneumococcal Shots
- Sexually Transmitted Infection (STI) Screening and Counseling
- Smoking and Tobacco-Use Cessation (Counseling to Stop Smoking or Using Tobacco Products)
- Welcome to Medicare” preventive visit
- Yearly “Wellness” visit

The “Welcome to Medicare” preventive visit, also called the “Initial Preventive Physical Examination” (IPPE), is a great way to get up-to-date information on important screenings and vaccines and to review your medical history. It’s only offered one time within the first 12 months of getting Medicare Part B.

During your preventive visit, your doctor or health care provider will perform the following services:

- Review your medical and social history related to your health; and, a review of opioid use/Opioid Use Disorder (OUD) which is a routine component of this element
- Review potential risk factors for depression and other mood disorders
- Review functional ability and level of safety (an assessment of hearing impairment, ability to successfully perform activities of daily living, fall risk, and home safety)
- Measure your height, weight, body mass index (BMI), and visual acuity screening
- End-of-life planning (upon your agreement)
- Educate, counsel, and make referrals based on your visit
- Educate, counsel, and make referrals for other preventive services, including a brief written plan like a checklist

You’ll get advice to help you prevent disease, improve your health, and stay well. You’ll also get a brief written plan (like a checklist), letting you know which screenings and other preventive services you need.

There’s no cost if your doctor accepts Medicare assignment, unless your doctor or other health care provider performs additional tests or services during the same visit that aren’t covered under the preventive benefits. If so, you may have to pay coinsurance, and the Part B deductible may apply.

**IMPORTANT**: This service is a preventive visit and not a routine physical checkup. The “Welcome to Medicare” preventive visit doesn’t include any clinical lab tests.

For more information about what is included and billing information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7079.pdf.
Yearly “Wellness” Visit

After you’ve had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a prevention plan just for you. Medicare covers one yearly “Wellness” visit every 12 months.

You don’t need to get the “Welcome to Medicare” preventive visit before getting a yearly “Wellness” visit. If you got the “Welcome to Medicare” preventive visit, you’ll have to wait 12 months before you can get your first yearly “Wellness” visit. Medicare will cover a yearly “Wellness” visit at no cost to you. You can work with your doctor to develop and update your personalized prevention plan. This benefit provides an ongoing focus on prevention that can be adapted as your health needs change over time. Advance care planning is included.

You’ll pay nothing for this exam if the doctor accepts assignment, unless your doctor or other health care provider performs additional tests or services during the same visit that aren’t covered under the preventive benefits. If so, you may have to pay coinsurance, and the Part B deductible may apply.

**IMPORTANT:** The yearly “Wellness” visit isn’t a routine physical checkup.

Yearly “Wellness” Visit Provides Personalized Prevention Plan Services

Your doctor or other health care provider will ask you to answer some questions before your visit. This is called a “Health Risk Assessment” (HRA). Your responses to the questions will help you and your doctor or other health care provider get the most from your “Wellness” visit and all subsequent yearly “Wellness” visits.

During the visit, your doctor or other health care provider will

- Review the HRA
- Create a current list of your providers and suppliers
- Review your medical, family, and social history related to your health (a review of opioid use/Opioid Use Disorder (OUD) is a routine component of this element)
- Measure your height, weight, BMI, and blood pressure
- Review your functional ability and level of safety
  - Detection of any cognitive impairments you may have
  - Establish a written screening schedule (like as a checklist)
  - Establish a list of risk factors
  - Provision of personalized health advice and referral to appropriate health education or other preventive services

For more information visit: CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18004.pdf

### Subsequent Yearly “Wellness” Visits

Subsequent yearly “Wellness” visits providing personalized prevention plan services (PPPS) include the following:

- A review of your updated HRA
- Updates to your medical, family, and social history related to your health (a review of opioid use/OUD is a routine component of this element)
- Updates to your list of current medical providers and suppliers
- Measurements of your weight and blood pressure
- Detection of any cognitive impairment that you may have
- Updates to your written screening schedule (like a checklist)
- Updates to your list of risk factors
- Personalized health advice and a referral to appropriate health education or other preventive services

### Abdominal Aortic Aneurysm Screening

Medicare Part B covers a one-time abdominal aortic aneurysm (AAA) ultrasound for people at risk. You must get a referral for it from your doctor.

The aorta is the largest artery in your body. It carries blood away from your heart. When it reaches your abdomen, it’s called the abdominal aorta. The abdominal aorta supplies blood to the lower part of the body. When a weak area of the abdominal aorta expands or bulges, it’s called an abdominal aortic aneurysm.
Aneurysms develop slowly over many years and often have no symptoms. If an aneurysm expands rapidly, tears open (ruptured aneurysm), or blood leaks along the wall of the vessel (aortic dissection), serious symptoms may suddenly develop.

For a one-time screening ultrasound, you must get a referral from your doctor, physician’s assistant, nurse practitioner, or clinical nurse specialist.

You’re considered at risk if any of the following apply to you:

- A family history of abdominal aortic aneurysms, or
- You’re a man 65 to 75 and have smoked at least 100 cigarettes in your lifetime, or
- You’re a person with Medicare who has other risk factors (i.e., heart disease, high blood pressure, and obesity) in a category recommended for screening by the U.S. Preventive Services Task Force regarding abdominal aortic aneurysms, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

- If any of these apply to you, Medicare covers a one-time screening abdominal aortic aneurysm ultrasound with no cost if the doctor or qualified health care provider accepts assignment.

For more information on risk factors, testing, and symptoms, visit uspreventiveservicestaskforce.org/Home/GetFileByID/1874

Alcohol Misuse Screening and Counseling

Medicare covers an annual alcohol misuse screening. Various screening tools are available to determine alcohol misuse. Medicare doesn't identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

For those who screen positive, Medicare covers up to 4 brief (15-minute), face-to-face behavioral counseling interventions per year for people with Medicare (including pregnant women) who meet the following requirements:

- Misuse alcohol, but whose levels or patterns of alcohol consumption don’t meet criteria for alcohol dependence (defined as at least 3 of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; use continues despite adverse consequences).
- Are competent and alert at the time that counseling is provided.
- Counseling is furnished by qualified primary care doctors or other primary care practitioners in a primary care setting.
- A primary care setting is defined as one in which there's provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and hospices aren’t considered primary care settings under this definition.

For more Medicare coverage information on alcohol misuse screening, visit Medicare.gov/coverage/alcohol-misuse-screenings-counseling. For more information, visit CDC.gov/vitalsigns/alcohol-screening-counseling.

**Bone Mass Measurement (Bone Density)**

Osteoporosis is a disease in which your bones become weak and are more likely to break. It’s a silent disease, meaning that you may not know you have it until you break a bone.

Medicare covers bone mass measurements to measure bone density. These test results help you and your doctor choose the best way to keep your bones strong.

Bone mass measurement is covered once every 24 months, or more often if medically necessary, you’re at risk for osteoporosis, or you meet one or more of these conditions:

- You’re a woman whose doctor or qualified health care provider determines your estrogen-deficient and at risk for osteoporosis based on your medical history and other findings
- Your X-rays show possible osteoporosis, osteopenia, or vertebral abnormalities
- You’re receiving (or expecting to receive) steroid therapy for more than 3 months
- You have primary hyperparathyroidism
- You’re being monitored to assess your response to U.S. Food and Drug Administration-approved osteoporosis drug therapy

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

For more Medicare coverage information on bone mass measurement, visit Medicare.gov/coverage/bone-mass-measurements. For information about osteoporosis, visit Medlineplus.gov/osteoporosis.html.

**Breast Cancer Screening (Mammograms)**

Breast cancer is the most frequently diagnosed non–skin cancer in women. It’s second only to lung cancer as the leading cause of cancer-related deaths among women in the U.S. Every woman is at risk, and this risk increases with age.

A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease. The procedure includes a doctor’s interpretation of the results.

Medicare provides coverage of one baseline screening mammogram for women between 35 and 39. Medicare also provides coverage of screening mammograms once every 12 months for women who are 40 and older.

You don’t need a doctor’s referral, but the X-ray supplier will need to send your test results to a doctor.

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

Diagnostic mammograms are done to check for breast cancer in men and women after a lump or other sign of breast cancer is found, if you have a history of breast cancer, or if your doctor judges by your history and other significant factors that a mammogram is appropriate. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

For Medicare coverage information on breast cancer screening and mammograms, visit Medicare.gov/coverage/mammograms.html.
Medicare covers intensive behavioral therapy for cardiovascular disease (referred to as a CVD risk reduction visit).

Medicare covers one face-to-face CVD risk reduction visit per year. Counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting (like a doctor’s office).

A primary care setting is defined as one in which there’s a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, SNFs, inpatient rehabilitation facilities, and hospices aren’t considered primary care settings under this definition.

The CVD risk reduction visit consists of these components:

- Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men 45–79 and women 55–79
- Screening for high blood pressure in adults 18 or older
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular-and diet-related chronic disease

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on cardiovascular disease (behavioral therapy), visit
Medicare.gov/coverage/cardiovascular-behavioral-therapy.

Cardiovascular Disease Screenings

Medicare covers cardiovascular screening tests that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke.

Lipid panel tests that include total cholesterol, high-density lipoproteins (HDL) cholesterol, and triglyceride levels are covered once every 5 years for all people with Medicare who have no apparent signs or symptoms of cardiovascular disease. In Original Medicare, there’s no cost if the doctor or other qualified health care provider accepts assignment.

For Medicare coverage information on cardiovascular disease screenings, visit
Cervical and Vaginal Cancer Screenings

Medicare covers Pap tests (Papanicolaou test), pelvic exams, and clinical breast exams.

- The screening Pap test covered by Medicare is a laboratory test that consists of a routine exfoliative cytology test provided for the purpose of early detection of cervical cancer. It includes collection of a sample of cervical cells and a doctor’s interpretation of the test.

- A screening pelvic examination is performed to help detect fibroids (benign tumors in women of childbearing age), pre-cancers, genital cancers, infections, sexually transmitted infections (STIs), other reproductive system abnormalities, and genital problems.

- In addition, a Medicare-covered screening pelvic examination includes a clinical breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer.

These tests are covered services for all women with Medicare, and will usually be performed during the same office visit. These services are covered once every 24 months for most women. However, they may be covered every 12 months if one of the following applies:

- You’re at high-risk for cervical or vaginal cancer (based on your medical history or other findings)
- You’re of childbearing age, and had an abnormal Pap test in the past 36 months

High-risk factors for cervical or vaginal cancer include the following:

- Early onset of sexual activity (under 16)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including human immunodeficiency virus)
- Fewer than 3 negative or no Pap tests within the previous 7 years
- Daughters of women who took diethylstilbestrol (DES) during pregnancy

Part B also covers human papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you’re 30–65 without HPV symptoms.

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on cervical and vaginal cancer screenings, visit Medicare.gov/coverage/cervical-vaginal-cancer-screenings.html.

Cardiovascular Disease Screenings

In the U.S., colorectal cancer is the fourth most common cancer in men and women. If caught early, it’s often curable.

To help find pre-cancerous growths and help prevent or find cancer early when treatment is most effective, your doctor may order one or more of the following tests (if you meet certain conditions): screening fecal occult blood test, screening flexible sigmoidoscopy, screening colonoscopy, barium enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy), or a multi-target stool DNA test.

Medicare defines high-risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or polyps
- Family history of familial polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis

For people with Medicare at high-risk of developing colorectal cancer, the frequency of covered screening tests varies from the frequency of covered screenings for those not considered at high-risk.

All people with Medicare 50 and older who aren’t at high-risk for colorectal cancer are covered for the following screenings:

- Fecal-occult blood test once every 12 months for people 50 or over
- Flexible sigmoidoscopy once every 48 months after the last flexible sigmoidoscopy or barium enema, or 120 months after a previous screening colonoscopy
- Colonoscopy once every 120 months, or 48 months after a previous flexible sigmoidoscopy
All people with Medicare 50 and older who are at high-risk for colorectal cancer are covered for the following screenings:

- Colonoscopy once every 24 months

There's no cost for fecal occult blood tests, flexible sigmoidoscopy, and colonoscopy if the doctor or other qualified health care provider accepts assignment.

**NOTE:** If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

All people with Medicare 50 and older who aren't at high-risk for colorectal cancer are covered for the following screenings:

- Barium enema once every 48 months when used instead of a flexible sigmoidoscopy or colonoscopy.
- Multi-target stool DNA test once every 3 years. Cologuard™ is not a replacement for diagnostic colonoscopy or surveillance colonoscopy in high-risk individuals.

All people with Medicare 50 and older who are at high-risk for colorectal cancer are covered for the following screenings:

- Barium enema once every 24 months as an alternative to a covered screening colonoscopy or flexible sigmoidoscopy

For barium enemas, you pay 20% of the Medicare-approved amount for the doctor’s services. The Part B deductible doesn’t apply. If it’s done in a hospital outpatient setting, you pay a copayment. There’s no cost for the multi-target stool DNA test if the provider accepts assignment.

**Depression Screening**

Medicare covers an annual screening for depression for people with Medicare in a primary care setting that has staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

Various screening tools are available for the screening of depression. Medicare doesn't identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.

Coverage is limited to screening services and doesn't include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression. Furthermore, the depression screening doesn't address therapeutic interventions like pharmacotherapy (treatment with drugs), combination therapy (counseling and medications), or other interventions for depression.

Among people older than 65, one in 6 suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, like the loss of friends and loved ones, are also risk factors for depression.

Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

**Older adults have the highest risk of suicide of all age groups.**

It's estimated that 50%–75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% were seen during the week prior to their death.

_for Medicare coverage information on colorectal cancer screenings, visit Medicare.gov/coverage/screening-colonoscopies._
Symptoms of major depression that are felt nearly every day include, but aren't limited to: feeling sad or empty, less interest in daily activities, weight gain or loss (when not dieting), less ability to think or concentrate, tearfulness, feelings of worthlessness, and thoughts of death or suicide.

You pay nothing for this test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20% of the Medicare-approved amount for the other service and the Part B deductible may apply.

For Medicare coverage information on depression screenings, visit Medicare.gov/coverage/depression-screenings.html.

**Diabetes Screenings**

Diabetes is a disease in which your blood glucose, or sugar levels, are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy.

With Type 1 diabetes, your body doesn’t make insulin. With Type 2 diabetes, the more common type of diabetes, your body doesn’t make or use insulin well. Without enough insulin, the glucose stays in your blood.

Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes is the leading cause of acquired blindness among adults in the U.S. It can also cause heart disease, stroke, and even the need to remove a limb.

People at risk are those with high blood pressure, high cholesterol and triglyceride levels, obesity, and a history of high blood sugar.

Medicare covers diabetes screenings for all people with Medicare with certain risk factors for diabetes or diagnosed with pre-diabetes, like people who are 65 and older, overweight, have a family history of diabetes, and a history of gestational diabetes or delivery of a baby weighing more than 9 pounds.

The diabetes screening test includes a fasting blood glucose test.

Talk with your doctor about how often you should get tested. For people with pre-diabetes, Medicare covers a maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart). For people without diabetes, who haven’t been diagnosed as pre-diabetic or who have never been tested, Medicare covers one diabetes screening test within a 12-month period. A normal fasting blood sugar level is 100 mg/dL. Diabetes diagnosis occurs at 126 mg/dL, and a person with blood sugar readings between 101–125 mg/dL is considered pre-diabetic.

Medicare provides coverage for diabetes screenings as a Medicare Part B benefit after a referral from a doctor or qualified provider for an individual at risk for diabetes. You pay nothing for these tests if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on diabetes screenings, visit Medicare.gov/coverage/diabetes-screenings.html.

**Medicare Diabetes Prevention Program (MDPP)**

The Medicare Diabetes Prevention Program (MDPP) is a free covered service under Medicare. It’s continuing to grow across the country. It’s based on a successful, proven model for diabetes prevention using a Centers for Disease Control (CDC)-approved curriculum.

It helps people with Medicare make behavioral changes to prevent or delay Type 2 diabetes in individuals with an indication of pre-diabetes and other serious health problems through dietary change, increased physical activity, and weight loss strategies. It’s been shown to lower the risk of developing Type 2 diabetes by as much as 71% in individuals over 60.

MDPP uses face-to-face coaching sessions. It’s the first-time community-based organizations, like your local YMCA or health center can apply to offer these services to people with Medicare. Participants must get a blood test from their doctor to identify pre-diabetes and the doctor must recommend that they participate in MDPP. Then, they can enroll in MDPP with an organization that’s a Medicare-approved supplier.

- People who participate in the program report feeling better, being more active, and having more self-confidence (there are additional benefits beyond preventing diabetes)
- With the changes individuals make to their diet and physical activity, they may be able to manage other conditions without taking medications
Remember, this is a new program that’s still ramping up, so don’t be discouraged if you don’t see an organization that offers these services in your community listed on Medicare.gov yet. Keep checking the list, which Medicare plans to update frequently. Work with your doctor on diabetes prevention in the meantime.

For more information, visit innovation.cms.gov/initiatives/medicare-diabetes-prevention-program and Medicare.gov/coverage/diabetes-prevention-program.

Covered Diabetes Supplies and Services

Medicare Part B covers some diabetes supplies and services, including insulin pumps, special foot care, and therapeutic shoes for people with diabetes who need them.

Insulin associated with an insulin pump is covered by Medicare Part B. Injectable insulin not associated with the use of an insulin pump is covered under Medicare prescription drug coverage (Part D).

In Original Medicare, you pay 20% of the Medicare-approved amount after the yearly Part B deductible for a glucometer, lancets, and test strips.

Medicare provides coverage for diabetes-related durable medical equipment (DME) and supplies as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier doesn’t accept assignment, the amount you pay may be higher. In this case, Medicare will provide you with payment of the Medicare-approved amount.

Continuous glucose monitors (CGMs) monitor a patient’s glucose level on a continuous basis (for example, every 5 minutes). Some therapeutic CGMs approved by the U.S. Food and Drug Administration (FDA) are considered DME if used to replace a blood glucose monitor for use in making diabetes treatment decisions.


For more information, please review “Medicare Coverage of Diabetes Supplies & Services” (CMS Product No. 11022) at Medicare.gov/Pubs/pdf/11022-Medicare-Diabetes-Coverage.pdf.

Medicare also covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

For Medicare coverage information on foot care, visit medicare.gov/coverage/foot-care.

Diabetes Self-Management Training

Medicare provides coverage of diabetes self-management training (DSMT) services for people with Medicare who have recently been diagnosed with diabetes, were determined to be at risk for complications from diabetes or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for Medicare.

DSMT services are furnished by certified providers who meet certain quality standards in diabetes self-management education, including, for example, some hospitals, doctors and registered dietitians or nutrition professionals. DSMT is intended to help you self-manage your diabetes condition. It may include education about how to monitor your blood sugar, tips about a healthy diet and exercise, taking medication, and an insulin treatment plan if you’re insulin-dependent.

Medicare Part B covers up to 10 hours of initial training—one hour of individual and 9 hours of group—of DSMT services during the initial training year (continuous 12-month time period). You may also qualify for up to 2 hours of follow-up training each year if it takes place in a calendar year (CY) after the year you got your initial training. You must get an order from your doctor or qualified non-physician practitioner (NPP) who has been treating your diabetes for the initial training and each CY follow-up training.
Exception for individual services instead of group: You can get individual sessions if no group session is available, or if your doctor or qualified NPP says you have special needs that would prevent you from participating effectively in group training. The 2 hours of follow-up training can be individual without needing to meet the special needs criteria. The doctor or NPP makes the individual or group determination on your referral for DSMT services.

If you live in a rural area, you may be able to get DSMT services from a practitioner, like a registered dietitian or nutrition professional (who has met the diabetes education qualification standards), in a different location through telehealth (Medical or other health services given to a patient using a communications system (like a computer, phone, or television) by a practitioner in a location different than the patient’s.).

The Medicare Part B deductible and coinsurance or copayment apply to DSMT services.

Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during the winter months. It attacks the respiratory tract in humans (nose, throat, and lungs). Influenza can lead to pneumonia.

Medicare Part B provides coverage of one seasonal flu shot per flu season for all people with Medicare. This may mean that people with Medicare may receive more than one seasonal flu shot in a 12-month period. Medicare may provide coverage for more than one seasonal flu shot per flu season if a doctor determines, and documents in your medical record, that the additional shot is reasonable and medically necessary. For example, if you get a flu shot late in the flu season in January 2019, you will also be covered if you get a shot in October, November, or December of 2019 because that’s the start of a new flu season.

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

**For Medicare coverage information on flu shots, visit Medicare.gov/coverage/flu-shots.html.**

**Glaucoma Tests**

Glaucoma is an eye disease caused by above-normal pressure in the eye. It usually damages the optic nerve and you may gradually lose sight without symptoms. It can result in blindness, especially without treatment.

The best way for people at high-risk for glaucoma to protect themselves is to have regular eye exams.

You’re considered high-risk for glaucoma and eligible for Medicare coverage of the glaucoma test if any of the following apply:

- You have diabetes
- You have a family history of glaucoma
- You’re African American, 50 or older
- You’re Hispanic American, 65 or older

An eye doctor who’s legally authorized by the state must perform the test. You pay 20% of the Medicare-approved amount and the Part B deductible applies for the doctor’s visit. In a hospital outpatient setting, you pay a copayment.

**NOTE:** Medicare doesn’t provide coverage for routine eye refractions (vision tests).

For Medicare coverage information on glaucoma tests, visit Medicare.gov/coverage/glaucoma-tests.html.

**Hepatitis B Shots**

Hepatitis B is a serious disease caused by the Hepatitis B virus (HBV). The virus can affect people of all ages. Hepatitis B attacks the liver and can cause chronic (lifelong) infection, resulting in cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

Medicare provides coverage for the Hepatitis B vaccine (series of shots) and its administration for people with Medicare at intermediate or high-risk of contracting HBV.
High-risk groups currently identified include the following:

- Individuals with ESRD
- Individuals with hemophilia who received Factor VIII or IX
- Individuals with diabetes mellitus
- Clients of institutions for the developmentally disabled
- Individuals who live in the same household as an HBV carrier
- Men who have sex with men
- Illicit injectable drug users

Intermediate risk groups currently identified include the following:

- Staff in institutions for the developmentally disabled
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

In Original Medicare, there’s no cost for the shot if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on Hepatitis B shots, visit Medicare.gov/coverage/hepatitis-b-shots.html.

**Hepatitis B Virus Infection Screening Tests**

Medicare will only cover Hepatitis B virus infection screening tests if they are ordered by a primary care doctor or practitioner in a primary care setting and they meet the following conditions:

- Asymptomatic non-pregnant adolescents and adults at high-risk for HBV infection
- Annually, for continued high-risk individuals who don’t receive Hepatitis B vaccination
- Pregnant women at the first prenatal visit for each pregnancy, and rescreening at the time of delivery for those with new or continued risk factors

Hepatitis C virus (HCV) is an infection that attacks the liver, and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis.

A cirrhotic liver fails to perform the normal liver functions, which leads to liver failure. Cirrhotic livers are more prone to become cancerous, and liver failure leads to serious complications, even death.

This screening is covered when ordered by a primary care practitioner within the context of a primary care setting for people with Medicare who meet any of the following conditions:

- High-risk because you have a current or past history of illicit injection drug use
- Had a blood transfusion before 1992
- Born between 1945–1965

People born from 1945–1965 are 5x more likely to have Hepatitis C

More than one million people living with Hepatitis C do not know they are infected

Left untreated, Hepatitis C can cause liver damage failure and cancer

Many people can live with Hepatitis C for decades with no symptoms

Talk to your doctor. A blood test is the only way to know if you have Hepatitis C. Treatments are available that can cure this disease.
Medicare also covers yearly repeat screenings for certain people at high-risk.

The determination of “high-risk for HCV” is identified by the primary care doctor or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual “Wellness” visit, and considered in the development of a comprehensive prevention plan. The medical record should reflect the service provided. In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on Hepatitis C screening, visit Medicare.gov/coverage/hepatitis-c-screening-tests.

HIV (Human Immunodeficiency Virus) Screening

Human immunodeficiency virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV attacks the immune system by destroying a type of white blood cell that is vital to fighting off infection. Once infected, it may take years for recognizable illness to develop. Thus, a person may be infected with HIV for years before the condition is suspected.

Medicare covers one annual voluntary HIV screening for people with Medicare between 15 and 65, without regard to perceived risk. Except for pregnant women with Medicare, Medicare will also cover one annual, voluntary screening for people who are younger than 15 or older than 65, who are at increased risk for the infection. However, for people with Medicare who are pregnant, Medicare covers up to 3 voluntary screenings during a pregnancy.

The following people are considered at increased risk for HIV infection:
- Men who have sex with men
- Men and women having unprotected sex
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons who have acquired or request testing for other sexually-transmitted infectious diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request the HIV test despite reporting no individual risk factors
- Persons with new sexual partners
- Persons whose individualized medical history, as properly assessed and documented by an appropriate health care professional, indicates an increased risk for the disease

For people with Medicare who are pregnant, up to 3 voluntary screenings during a pregnancy are covered. There’s no cost for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor’s visit.
Lung Cancer Screening

Medicare covers lung cancer screening with low-dose computed tomography (x-ray machine scans the body and uses low doses of radiation to make detailed pictures of the lungs) once per year for people with Medicare who meet these criteria:

- Are asymptomatic (you don’t have signs or symptoms of lung cancer),
- Are 55-77,
- Are either a current smoker or have quit smoking within the last 15 years,
- Have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years), and
- Get a written order from their doctor or qualified non-physician practitioner

Before your first lung cancer screening, you’ll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

In Original Medicare, there’s no cost if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on lung cancer screening, visit Medicare.gov/coverage/lung-cancer-screenings.

Medical Nutrition Therapy (MNT) Services

Medicare Part B covers medical nutrition therapy (MNT) services and certain related services.

A registered dietitian or nutrition professional who meets certain requirements can provide these services, which may include an initial nutrition and lifestyle assessment, individual and/or group nutritional counseling, and follow-up visits to check on your progress in managing your diet.

If you’re in a rural area, a registered dietitian or other nutritional professional in a different location may be able to provide MNT to you through telehealth.

If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care.

People with Part B who meet at least one of these conditions are eligible:

- Have diabetes
- Have kidney disease
- Have had a kidney transplant in the last 36 months

People with Part B must get a referral from their doctor. There’s no cost for MNT services if the registered dietitian or nutrition professional accepts assignment.
Obesity Screening and Counseling

Clinical evidence indicates that intensive behavioral therapy for obesity, defined as a BMI $\geq 30$ kg/m$^2$, is reasonable and necessary for the prevention or early detection of illness or disability. It’s appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period.

Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m$^2$)
- Dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high-intensity interventions of diet and exercise

For people with Medicare with obesity, who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care doctor or other primary care practitioner in a primary care setting, Medicare covers one face-to-face visit every

- Week for the first month
- Every other week for months 2–6
- Month for months 7–12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement as discussed below

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.

To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, people must have achieved a reduction in weight of at least 3 kg (6.6 lbs.) over the course of the first 6 months of intensive therapy.

This determination must be documented in the doctor’s office records, consistent with usual practice. For those who don’t achieve a weight loss of at least 3 kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

This counseling may be covered if you get it in a primary care setting (like a doctor’s office), where it can be coordinated with your other care and a personalized prevention plan. There’s no cost if the doctor or qualified health care provider accepts assignment.

For Medicare coverage information on obesity screening and counseling, visit Medicare.gov/coverage/obesity-behavioral-therapy.

For more information, visit CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7641.pdf.

Pneumococcal Shot

Medicare Part B covers a pneumococcal shot to prevent pneumococcal infections (like certain types of pneumonia). Medicare covers the following:

- An initial pneumococcal shot for all people with Medicare who’ve never received the shot under Medicare Part B
- A different second pneumococcal shot if it’s given at least one year (or later) after the first shot

Medicare doesn’t require that a doctor order the vaccines; therefore, people with Medicare may get the vaccine upon request without a doctor’s order and without doctor supervision. Medicare Part B covers these vaccines.

You pay nothing for pneumococcal shots if your doctor or other qualified health care provider accepts assignment.

For Medicare coverage information on pneumococcal shots, visit Medicare.gov/coverage/pneumococcal-shots.html.
Prostate Cancer Screening

All men are at risk for prostate cancer. However, the causes of prostate cancer aren’t yet clearly understood. Through research, several factors have been identified that increase your risk, including the following:

- Family history of prostate cancer
- Men 50 and older
- Diet of red meat and high fat dairy
- Smoking

Medicare provides coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer once every 12 months for all men with Medicare 50 and older (coverage begins the day after their 50th birthday). The 2 most common screenings used by doctors to detect prostate cancer are the screening Prostate-Specific Antigen (PSA) blood test and the screening digital rectal examination.

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B once every 12 months, or at certain times during pregnancy. These screenings are covered for sexually active adolescents and adults at increased risk for STIs, if referred by a doctor and for certain people who are at increased risk for an STI when a doctor orders the tests.

For Medicare coverage information on prostate cancer screening, visit Medicare.gov/coverage/prostate-cancer-screenings.html.

For Medicare coverage information on STI screening and counseling, visit Medicare.gov/coverage/sexually-transmitted-infections-screenings-counseling.
Smoking and Tobacco Cessation (Counseling to Stop Smoking or Using Tobacco Products)

Tobacco use continues to be the leading cause of preventable disease and death in the U.S. Smoking can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare covers counseling to prevent tobacco use for outpatient and hospitalized people with Medicare

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease?
- Who are competent and alert at the time that counseling is provided?
- Whose counseling is furnished by a qualified doctor or other Medicare-recognized practitioner

Medicare will cover up to 8 face-to-face smoking and tobacco-use cessation counseling visits in a 12-month period.

Tobacco cessation counseling services can be provided in the hospital, or on an outpatient basis. However, tobacco cessation counseling services aren’t covered if the primary reason for the hospital stay is tobacco cessation. You must get counseling from a qualified Medicare provider (doctor, doctor’s assistant, nurse practitioner, clinical nurse specialist, or clinical psychologist).

You pay nothing for the counseling sessions if they’re furnished by a doctor or other health care provider who accepts assignment. A copayment may apply in a hospital outpatient setting.

Medicare’s Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a doctor.

For Medicare coverage information on smoking and tobacco-use cessation counseling, visit Medicare.gov/coverage/smoking-tobacco-use-cessation-counseling

Working After 65? Avoid 5 Medicare Pitfalls

Learn how Medicare works if you are still employed after 65.

Key Takeaways

- Your health insurance generally terminates when you leave your job. Apply for Medicare 2 to 3 months before you end employment to avoid a gap in coverage.
- If you enrolled in Social Security before your 65th birthday, you will be enrolled automatically in Medicare Parts A and B. However, if you are still covered by an employer’s health plan, you could be paying for 2 plans.
- Speak with your HR department to coordinate the timing and coverage options between your employer plan and Medicare as you approach age 65.

As you turn age 65, your mailbox will likely be full of birthday cards, well wishes, and a deluge of information packets on Medicare, the government health care program for people age
65 and over. But what if you’re not ready to retire? Do you keep your employer-sponsored health care coverage or go for Medicare?

Today, more than 23% of baby boomers* are choosing to continue to work, either part-time or full-time, beyond age 65. Although most retirees enroll in Medicare at age 65, if you’re still working, you have more options to consider for quality health care coverage—and the information in the Medicare brochure you receive from Uncle Sam may not be suitable for your situation because Medicare does not know whether you are still working.

There’s a lot to keep track of: enrollment deadlines, health care coverage options, and possible penalties to avoid. But with some planning and homework, you can avoid the common pitfalls if you continue to work beyond age 65.

**Medicare Basics**

Because Medicare works very differently from employer health insurance, there are lots of things to learn. If you continue to work after reaching age 65, you technically become eligible for Medicare, but you may or may not want to enroll right away.

Here’s the dilemma: Your employer must continue to cover all eligible workers, regardless of age, under its group health insurance—yet, Medicare is telling you to sign up now.

It may not be clear that you only need to sign up for Medicare once—at the point when your employer group coverage is ending—so here’s the 2-part general rule for when to join Medicare:

1. Enroll during your Initial Enrollment Period (IEP)—3 months before to 3 months after the month you turn age 65; but only if
2. You also lose access to your employer group health insurance coverage.

If you don’t enroll during your IEP because you have employer group health insurance coverage, you can enroll at any time you still have employer group coverage or within 8 months after the month your employment or group coverage ends—whichever happens first. You’ll need to know what your coverage options will be at age 65 and adjust your Medicare enrollment to meet your needs.

One other situation that can cause confusion occurs if you leave your job with a “retiree” health care plan or coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985). Neither of these health insurance options is considered employer group health insurance coverage, so you would be classified as a “former worker.” In this case, you would need to enroll in Medicare during your IEP.
Who Pays First?

As with many laws and regulations, the devil is in the details. In the case of health insurance, you need to know who the “primary payer” is—the party responsible for paying your medical bills first and covering many of the costs.

- Medicare becomes the primary payer for your health care expenses once you reach age 65 and lose your employer group coverage (assuming you work for an employer with more than 20 employees)
- If you continue to work, your employer’s insurance pays first
- And, if you’ve already left the company and have a retiree plan or COBRA, those plans typically become the secondary payer the month you turn age 65. So, if you don’t have Medicare in place already, you become the primary payer.

If you work for an employer with fewer than 20 employees, you need to enroll in Medicare at age 65, during your IEP. Medicare becomes the primary payer and your employer’s insurance becomes secondary.

5 Pitfalls to Avoid When Working Past Age 65

1. Not Doing Your Homework:

If you plan to work past age 65, or if your spouse or partner continues to work and covers you, you’ve got some research to do to make sure you know your options, the costs, and any restrictions.

- Your employer is required to offer you coverage, but is that your best option?
- Is it more expensive to stay in your employer plan or join Medicare?
- Which plan offers you the best coverage for your health needs?
- Can your spouse or partner remain in your employer’s plan if you decide to leave?

Tip: Review your health benefits documents and schedule a call with your company’s HR or benefits group to discuss your insurance options.

For more information, contact Medicare at 1-800-Medicare.

2. Failing to notify Social Security that you want to delay Medicare:

If you enrolled in Social Security before your 65th birthday, you will be enrolled automatically in Medicare Parts A and B. However, if you are still covered by an employer’s health plan, you could be paying for 2 plans.

- If you signed up for Medicare as part of your Social Security application process (online, in person, or over the phone), you’ll need to contact the Social Security Administration by phone or by visiting your local office to explain that you do not want Part B at this time—that’s because Social Security manages the administration of Medicare.
- If you automatically receive your Medicare card, you’ll need to follow the instructions that came with the card to cancel your Part B coverage. Generally, there is a short time frame of several weeks to return your Medicare card and cancel enrollment.
- If you haven’t enrolled in Social Security by age 65, there is no automatic turn on of your Medicare benefit—you just continue as an active employee, and you can enroll in Social Security later.

3. Enrolling in Medicare Part A, but losing the ability to contribute to your health savings account (HSA):

Many employees with access to HSAs have funded their accounts hoping that they could use their HSA dollars to pay for qualified medical expenses in their retirement.

But here’s the glitch: If you enroll in any part of Medicare, you lose the ability to continue contributions to your HSA. Some people who continue to work after age 65 decide to enroll only in Medicare Part A because they think it’s free and that it may provide some secondary insurance coverage in the event of hospitalization; however, this move may have unintended consequences.

Tip: Decide which option is more important to you: the ability to continue to contribute to your HSA or enrolling in Medicare at age 65, because you cannot do both. When you enroll in Medicare after turning age 65, your actual coverage becomes effective up to 6 months earlier. Therefore, you’ll want to end contributions to your HSA at least 6 months prior to leaving your job. This will help you avoid a possible tax penalty for making ineligible contributions to your HSA after your Medicare coverage has kicked in.
4. Not coordinating the timing of your Part B with losing your employer group health plan coverage.

As you leave your job, your health insurance generally terminates at the end of that month. It's important to apply for Medicare a couple of months before you end employment so that your coverage will be in place on the first month of your retirement. Otherwise, you may have a gap in health insurance coverage leaving you fully responsible for paying any medical expenses you incur during this period.

**Tip:** Fill out the appropriate Medicare forms to enroll in Part B as your employer coverage is ending (Forms CMS-40B and CMS-L564). Do so about 3 months before your last day on the job.

For example, say you are age 68 and retire on March 15. The last day of your employer health coverage would be March 31. If you enrolled in Medicare in advance of your retirement, Medicare coverage would begin on April 1. If you wait until after you retire to enroll in Medicare, you will have a coverage gap. Your Medicare coverage could begin on May 1 or as late as December 1, and you would be responsible for paying any medical bills that you incur during those months without health care coverage.

5. Missing the "open enrollment period" to buy a Medigap plan after employer health insurance ends.

The timing for buying supplemental insurance such as a Medigap policy is different from enrolling in Medicare. If you decide to do so, you'll have 6 months to buy a Medigap plan without underwriting once you have enrolled in Part B and have been assigned your Part B plan number. You may be able buy a Medigap plan after the open enrollment period, but, generally, you then become subject to medical underwriting, and the insurance company can decline to sell you a policy or can charge you more.

For more information, visit [www.medicare.gov](http://www.medicare.gov) or contact 1-800-MEDICARE.

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**Does Medicare Cover in Home Care?**

Medicare will pay for many services that are considered home health care. Medicare part A covers home health care services such as speech and occupational therapy, medical equipment such as oxygen or wheelchairs and some medical supplies. Part A will also cover part time nurse assistance and medical social services.

Medicare part B also offers additional coverage for these same services. Most of the costs incurred by this type of service will be covered between both plans. Custodial care, care with personal hygiene, is not covered under any of the Medicare programs. If you are in a nursing home or have home health care assistance, any personal services rendered will be the responsibility of the patient.

**Home Health Covered Services**

If you qualify for the home health benefit, Medicare covers the following:

**Skilled nursing services:** Services performed by or under the supervision of a licensed or certified nurse to treat your injury or illness.

- Services you may receive include injections (and teaching you to self-inject), tube feedings, catheter changes, observation and assessment of your condition, management and evaluation of your care plan, and wound care.

- Provided up to seven days per week for generally no more than eight hours per day and 28 hours per week. In some circumstances, Medicare can cover up to 35 hours per week.
**Skilled therapy services:** Physical, speech, and occupational therapy services that are reasonable and necessary for treating your illness or injury and performed by or under the supervision of a licensed therapist.

- Physical therapy includes gait training and supervision of and training for exercises to regain movement and strength in a body area.
- Speech-language pathology services include exercises to regain and strengthen speech and language skills.
- Occupational therapy helps you regain the ability to do usual daily activities by yourself, such as eating and putting on clothes.

- **Home health aide:** Medicare pays in full for an aide if you require skilled care (skilled nursing or therapy services). A home health aide provides personal care services, including help with bathing, toileting, and dressing. Medicare will not pay for an aide if you only require personal care and do not need skilled care.

- **Medical social services:** Medicare pays in full for services ordered by your doctor to help you with social and emotional concerns you have related to your illness. This may include counseling or help finding resources in your community.

- **Medical supplies:** Medicare pays in full for certain medical supplies, such as wound dressings and catheters, when provided by a Medicare-certified home health agency (HHA).

- **Durable medical equipment (DME):** Medicare pays 80% of its approved amount for certain pieces of medical equipment, such as a wheelchair or walker. You pay 20% coinsurance (plus up to 15% more if your home health agency does not take assignment).

Medicare should pay for these services regardless of whether your condition is temporary or chronic.

**For information**

A lump-sum payout can give you the flexibility of choosing where to invest or save your money, and when and how much money to withdraw. However, it also shifts responsibility from your employer to you for making your money last and protecting it from a variety of risks ranging from inflation to fraud.

Here are things to know and do if you have the option of taking out a lump-sum payout on your pension:

- **Proceed with caution:** This is a one-time choice. Consider your health, and your overall retirement income and needs. If you are married, consider the long-term financial well-being of your spouse.

**Key Tips to Consider If Choosing a Lump-Sum Pension Payout**

Your pension plan may give you the option of taking your full pension in a lump sum when you retire. When you choose a lump-sum payout instead of a monthly pension payment, you replace a lifetime monthly payment for a one-time payout.

Ask your employer or plan administrator for more specific information about your payout options and their requirements and deadlines. Ask if your plan may allow a combination of payouts.
• **Detect and correct errors in your lump sum calculation:**
  Mistakes can happen. Many factors determine your lump sum payment amount including your age, years of work, your earnings history, taxes withheld, and the terms of your plan.

  Look at your most recent pension statement and verify that the information used to calculate your lump sum matches.

• **Plan for tax consequences:** You will pay taxes on your lump sum payout. Your lump sum money is generally treated as ordinary income for that year. For this reason, your employer is required to withhold 20 percent on the amount.

  In addition, you could pay a 10 percent early withdrawal penalty tax if you have not reached age 59½.

  If you don’t need all the money immediately, consider rolling it over into a qualified retirement account within 60 days of taking the lump sum. A qualified retirement account will protect your money from an early withdrawal penalty and defer income taxes until you take money out.

• **Make your money last:** You and your spouse may spend 20 or more years in retirement. For example, if you decide to invest or save your money the value of your lump sum can erode over time due to fees and commissions, poor stock market performance, and inflation. Seek help from financial professionals as needed.

• **Protect your money from fraud and scams:** Scammers and fraudsters often target older consumers. Be wary of anyone promising high investment returns and low risk and pressuring you to act quickly.

  Take your time. Verify information, ask questions, and seek advice from trusted professionals, family, and friends; this will help you spot a fraud or scam.

• **Plan:** Timing your retirement or separation date is the easiest way to maximize your payout options and the amount that you can get under each one of them.

  For more information, visit [https://www.consumerfinance.gov/about-us/blog/key-tips-to-consider-if-choosing-a-lump-sum-pension-payout/](https://www.consumerfinance.gov/about-us/blog/key-tips-to-consider-if-choosing-a-lump-sum-pension-payout/)

  "I am Psyched! For Healthy Aging"

  NCBA participated in "I am Psyched! For Healthy Aging", a free event in honor of the International Day of Older Persons. Renee J. Nash, director of News and Public Affairs, WHUR 96.3 FM, moderated this event celebrating the importance and beauty of healthy aging.

  The I am Psyched! initiative raised awareness about the contributions of women of color (WOC) to the field of psychology. The event brought four WOC psychologists performing innovative research together with older adults to discuss how psychology contributes to healthy aging. Angela Telesford, NCBA SCSEP Job Counselor and Program Participant shared her experiences in the workplace and what it means to remain active, creative, and healthy as we age.

  Ms. Telesford was joined by Gayle Skawennio Morse, PhD, Professor in the Psychology Department at Russell Sage who spoke to the benefits of remaining active and how working and remain engaged in activities with your friends, family, and in your community helps to thwart off isolation, depression and possibly chronic conditions.
NCBA Health and Wellness and DC SCSEP had its first annual “Employment and Health Expo” to introduce seniors to a variety of health prevention tips, information, screenings, educational programs, and employment opportunities.

Collaborating with CVS Health, Virginia Hospital Center, and Center for Medicare and Medicaid Services the expo was well-attend and deemed a success! Held at the SJS NCBA Estates, the event was open exclusively to seniors, including SJS residents and SCSEP participants.

The CVS Workforce Initiative Team displayed a table to explain their application process, the Virtual Job Tryouts (VJT), and to share their job listings. Any senior who needed additional help completing their application and/or who had questions about CVS had the opportunity to individually consult with a CVS team member.

Clinicians from Virginia Hospital Center provided an array of health materials and screenings, such as ask vision and hearing testing, blood pressure, stress booth, educational booths, diabetes education, fit demonstrations, and a nurse was on site to answer questions.

A liaison from the Center for Medicare and Medicaid Services (CMS), Office of Communication, Partner Relations Group was also on-site to answer questions and address existing and upcoming Medicare beneficiary concerns about how to use and leverage Medicare benefits beyond cost.

NCBA’s job placement program, SCSEP, works to help seniors gain financial independence with assistance in writing resumes and cover letters, building interview skills, and job application support.

NCBA would like to thank our partners for their outstanding commitment and service to our seniors and community. Our relationship has been invaluable, and it is with their support, that we can change the lives of seniors who may need financial stability or just want to stay active throughout their golden years.
50 Things You Can get for Free This Fall

We love a bargain, don’t you? In fact, free is our favorite four-letter word. To share the super-saver wealth, we’ve compiled 50 travel, self-care, beauty, pet care, family and home improvement freebies for fall. We’ve added links where search terms aren’t obvious. Enjoy!

Trip Savvy

1. National parks waive their entry fees on certain fee-free dates each year. In 2019, admission is free to 400-plus national parks — as well as national monuments and other sites — on the listed days including Nov. 11, Veterans Day.

2. On the road again? Use your iPhone or Android smartphone to download GasBuddy, an app that locates nearby stations with the best prices and start saving about $340 a year on gas!

3. Not knowing the language is no longer a barrier to traveling abroad. Let Google Translate be your guide. The one-stop translation spot allows you to type in a word or phrase and instantly have it translated into more than 100 languages. It even translates 59 languages without an internet connection.

4. Whether it’s a business trip, a family vacation or a quick fall getaway, TripIt will organize all your travel plans and documents in seconds. Simply download the mobile app and forward your confirmation emails to plans@tripit.com. For safety, TripIt will share your itinerary with those picking you up at the airport or anyone else who needs to know.

5. More money, more problems. Not with the XE Currency app for iPhone and Android, which offers current exchange rates, historical charts and on-the-go currency conversions.

6. Kick back and relax during your next hotel stay with a few homey freebies, including a warm welcome chocolate chip cookie at DoubleTree, access to your Netflix account at Marriott properties, hosted wine hours at Kimpton Hotels and a complimentary hot breakfast buffet at the budget-friendly Residence Inn and Comfort Inn hotels.

7. Oh snap! Save money on passport photos by taking your own picture and ordering it for free through ePassportPhoto.com.

8. Planning your autumn escape is easy with Free Travel Guides, free print and digital vacation planning and visitor guides from hundreds of destinations across the country. Find the latest attractions, where to eat, places to stay and discounts and coupons at travelguidesfree.com.

9. For those who prefer a personal touch, there are free tour guides you can ask to show you around your destination. The Global Greeter Network helps you find local volunteers in more than 200 foreign and domestic locations who love their city so much, they’ll accompany you for free.

10. If you’d rather go off on your own, girl, you can download free city audio guides from services such as iAudioguide.com.

11. Traveling on your birthday? Pull up your Starbucks app and sip your free pumpkin spice latte while you wait for your flight. Or get a caffeine boost at Au Bon Pain, which offers a free travel mug and daily fresh brew discounts when you join the email club.

12. Yay for Yapta — short for "your amazing personal travel assistant" — which monitors prices on all your company-booked flights and hotel rooms. When a price drops, yapta.com immediately shoots out a savings alert.

13. If you look up “third night free,” you will see dozens of offers from hotels that give you the last night free if you book a stay for three nights or longer. Participating hotel brands include Four Seasons and InterContinental Hotels & Resorts.

14. Planning to go over the river and through the woods to Granny’s house for Thanksgiving? Keep the kids busy by printing out some free travel games. Here are a few places to find them: Mama Cheaps, MiniTime and Pinterest.
Kitty Care and Puppy Love

15. Our furry friends can be finicky. Check out the Feed Pet Purveyor to sample a new brand of pet food or treats.

16. Vet bills are costly. But you can set up a free pet health exam at your local VCA animal hospital by filling out this VCA form.

17. Join the Petco Pals Rewards Club, and your pet will enjoy a special treat and message on their birthday. Even better, Petco offers free 30-minute dog-training classes (scroll down on their site to “Our Programs”) at select locations. PetSmart will also send a birthday surprise to your pet if you sign up for its rewards program.

18. You can nab a free Pet Safety Pack, which includes an ASPCA Animal Poison Control Center magnet and a pet rescue window decal, by filling out the ASPCA’s online form.

19. Ask and you shall receive — many restaurants including Chick-fil-A, Dairy Queen, Dunkin’ and Sonic will provide your pet with a free treat. Your canine or feline friend can also stay free at a variety of hotels, including Red Roof Inn and Kimpton Hotels.

20. K9-Cuisine is another company that generally will give you free dog food samples and treats.

21. Both cat and dog lovers can snag food and product samples from leading pet brands for free by signing up for PinchMe.

Home Improvement

22. Home Depot offers do-it-yourself classes for both adults and kids — for free. You can learn how to do everything from installing a ceiling fan to refreshing the look of your walls. Michaels craft stores also offer classes for both adults and kids. Some are free and some are available for a fee.

23. Planning to redesign or remodel a room? A free online room-design application can help. And you don’t even have to know anything about home-design software. A few to check out are Floorplanner, 3Dream and the Roomstyler 3D Room Planner.

24. And if you’re having trouble choosing a color? Try a free online color tool such as My Perfect Color, ColorSnap (snapshotyourcolors.com/) or Paint Colors Critique Corner.

25. Speaking of planning, you can also utilize free online tools to plot out the contents and layout of your next garden. You might want to check out Smart Gardener, Plan-a-Garden or the Online Kitchen Garden Planner. You can get a free 2019 Gardener’s Idea Book here — while supplies last.

26. One woman’s trash is another woman’s treasure. The Freecycle Network is a grassroots nonprofit that allows you to give and receive free stuff in cities and neighborhoods across the country by visiting freecycle.org. The idea is to keep good stuff out of landfills. Items range from free furniture to fabric, shelves and a whole host of other free household items.
27. You can also get free items for your home and garden on Craigslist just by going on the site and searching for, well, "free stuff."


29. To visualize how wallpaper will look in your home, order a few free wallpaper samples. On Walls Republic, you can order five free samples. Wallpaper Direct also offers free samples so that you can try before you buy.

30. Cleaning house? When it comes to household products, many companies like TheFreeSite.com, Hunt4Freebies or FreebieBlogger offer free samples.

**Self-Care and Fitness Freebies**

31. Trying to drop a few pounds before winter hibernation? Join an online weight loss support group or community on a platform like Supportgroups.com. Or for face-to-face motivation, go on Meetup to locate a weight loss support group near you.

32. Wanna get in shape without breaking the bank? A site called GymTicket offers a directory of more than 20,000 gyms across the country. You can find out which gyms give out free guest passes or are offering deals and promotions. Some gyms, such as Crunch Fitness and Anytime Fitness, will give you a free seven-day pass to try it out.

33. Focus on your breath and tune out stress with a free guided meditation that you can practice on your own. The UCLA Mindful Awareness Research Center offers several meditations you can stream or download both in English and Spanish. When it comes to free mindfulness apps, you might want to check out Headspace and Stop, Breathe & Think.

34. Keep your mind sharp and work your memory muscles by playing a variety of brain games from AARP. There’s everything from Sudoku to Mahjongg to crosswords.

35. Get free health screenings at Costco — available to both members and non-members. These screenings include heart, diabetes and osteoporosis checks. To find out what your local Costco offers, go to Costco.com and click on “Pharmacy” in the main menu.

36. Sam’s Club often offers free health screenings for members, including blood glucose. Cholesterol screenings are typically available to members for a small fee.

37. For older adults, there’s Medicare. And while Medicare isn’t free, of course, there are services with no out-of-pocket costs for Medicare beneficiaries. To help you determine what items and services are covered, check out Medicare’s relatively new free app called “What’s Covered,” which is available on both the App Store and Google Play. Just search for “What’s covered” or “Medicare,” and download the app to your phone.

38. Keep on walking with free apps like Map My Walk, Endomondo and the Fitbit App MobileTracker, which doesn’t require a Fitbit, to track your daily steps, speed, distance and calorie burn.

39. One of the most widely used apps is RunKeeper, which makes it easy to set up a running routine and to stick with it by tracking your progress. You can also use the app to track cycling and even ice-skating. Avid cyclists might also want to try Strava, which not only plots out your trips on a map, but also compares your abilities to others who have traveled the same route.

40. For workout inspiration, check out a variety of free fitness and workout playlists on Spotify. Start with the motivational Sisters from AARP “Woke Workout.”

**Beauty and Style**

43. Happy birthday to you! Many beauty and fashion brands give out free birthday gifts. But read the fine print: You usually must sign up for a free loyalty program in order to participate. Brands include The Body Shop and Bath & Body Works.
NCBA Supportive Services

The National Caucus & Center on Black Aging, Inc., (NCBA) one of our country’s oldest organizations dedicated to aging issues related to African American older adults. NCBA is also a leading authority when it comes to offering supportive services for older adults, including but not limited to safe and affordable housing; job training and employment opportunities; and health and wellness programming that promotes vitality at a mature age.

NCBA Supportive Services include:

Employment Opportunities

NCBA provides programs and services including employment training through its Senior Environmental Employment (SEE) Program and its Senior Community Service Employment Program (SCSEP).

To learn more about the Senior Community Service Employment Program (SCSEP), visit: https://www.ncba-aged.org/employment-program-resources.

To learn more about the Senior Employment Environment Program (SEE), visit: https://www.ncba-aged.org/environmental-employment-program-resources.

For Your Kids

44. Influenster is a product review platform for consumers. Sign up on the home page and you’ll soon receive offers by email, event invites and freebies. The site’s ongoing list of recent reviews of a variety of products is also interesting to peruse.

45. Sephora stores are notoriously good at giving out free samples of products, when asked. On the website, you’re also allowed to select up to two free samples when you place an order. These samples include everything from clay masks to lipsticks to sunscreen.

46. Find free samples of products related to health, fitness and wellness at MySavings.com, JustFreeStuff and Freaky Freddie’s.

47. Nordstrom department store salespeople will often give you a few samples if you are interested in trying a product. In addition, you get to choose three free samples when you make a purchase online of a skin care, fragrance, grooming or makeup item.

48. Your favorite college students can enjoy six months of Amazon Prime for free through Amazon Prime Student. Not only does this include free two-day shipping with no minimum purchase, there’s also the unlimited free streaming of movies and TV shows with Prime Video, unlimited Prime reading and unlimited storage for your photos. Just remember that after the six-month free period ends, they’ll automatically renew you for Amazon Prime at a special student rate. But you’ll have the opportunity to cancel before this happens.

49. Many museums across the country offer free or heavily discounted admission fees to students. For example, MoMA is free for New York City college students all year. (Children age 16 and younger are always free at MoMA.) Many museums on campuses also are free to students.

50. Depending on your location, kids age 5 and younger may be able to score free books once a month through Dolly Parton’s Imagination Library. There are also a growing number of Little Free Libraries popping up across the country, giving kids access to free books. And kids in certain states can get free books through Read Conmigo, an English-Spanish book program that supports bilingual learning in kids from preschool through fifth grade.
NCBA Health & Wellness

NCBA’s Health and Wellness Program advances the principles of health and wellness, vitality, and activity at a mature age.

The NCBA Health and Wellness Program promotes healthy living and disease prevention through nutrition, physical activity, early detection and screening with the intent of changing behaviors. The program addresses many health issues, including: cancer (breast, cervical and prostrate); cardiovascular disease; hypertension; HIV/AIDS; substance abuse; medication usage; Alzheimer’s Disease; nutrition; physical activity; access barriers (services and Care) and more.

To learn more about NCBA Health Program, visit: https://www.ncba-aged.org/health-and-wellness/

Housing

Established in 1977, the NCBA Housing Management Corporation (NCBA-HMC) is the organization’s largest program and service to seniors. NCBA-HMC provides senior housing for over 500 low-income seniors with operations in Washington, DC, Jackson, MS, Hernando, MS, Marks, MS, Mayersville, MS and Reidsville, NC.

To learn more about NCBA Housing Program, visit https://www.ncba-aged.org/affordable-housing/

As Medicare Open Enrollment approaches, people with Medicare can help protect themselves and the Medicare program from health care fraud

Last year, CMS removed Social Security numbers from all Medicare cards. Ahead of schedule, the agency completed a successful mailing brand new cards with a more secure Medicare number to protect Medicare beneficiaries. Even with this change, CMS is reminding people with Medicare to guard your Medicare card like a credit card, check Medicare claims summary forms for errors, and be wary of unsolicited requests for your Medicare number. Medicare will never call beneficiaries to ask for or check Medicare numbers.

To bring heightened public awareness to potential fraud and keeping your private healthcare and financial information safe, CMS is airing a national advertising campaign through October 14, the day before Open Enrollment begins. The ads will run on television and on digital platforms.

"Health care scammers will go to great lengths to steal from Medicare beneficiaries. That’s why guarding your Medicare card and personal information is essential,” said CMS Administrator Seema Verma. “You can protect yourself by knowing what to look for. Remember, if a caller says they’re from Medicare and asks for your Medicare number or other personal information – hang up. It’s probably a scam. Only give
your Medicare number to participating Medicare pharmacists, primary and specialty care doctors or people you trust to work with Medicare on your behalf.”

CMS officials also caution that healthcare fraud is a concern year-round and ongoing scams involve fraudulent health care screenings, genetic testing, lab work, and the sale of durable medical equipment (DME) like wheelchairs, walkers, canes and diabetic supplies.

Health care fraud occurs when someone steals or uses your Medicare number to submit fraudulent claims to Medicare without your authorization. It can disrupt your medical care and wastes taxpayer dollars. Remember to take your Medicare card with you for medical appointments and other covered Medicare health care services to ensure your information is filed with correct dates of services rendered and other required claim information.

To protect yourself from fraudsters, CMS offers the following security tips:

- Never accept medical supplies from a door-to-door salesman. If someone comes to your door claiming to be from Medicare, remember that Medicare and Medicaid do not send representatives to your home.

- Never give your Medicare card, Medicare number, Social Security card, or Social Security number to anyone except your doctor or people you know should have it.

- Remember, nothing is ever “free.” Never accept offers of money or gifts for free medical care.

- Be wary of providers who tell you that the item or service isn’t usually covered, but they “know how to bill Medicare” so Medicare will pay.

- Always check your medications before leaving the pharmacy to be sure you received the correct medication prescribed, including whether it’s a brand or generic name. If you don’t get your prescription filled correctly, report the problem to the pharmacist.

- Report suspected instances of fraud by contacting the HHS OIG Hotline or Medicare’s toll-free customer service operations at 1-800-MEDICARE (1-800-633-4227). You can also go online to find more information at our web resource -- www.medicare.gov/fraud.

For more information on CMS, visit cms.gov/newsroom, sign up for CMS news via email and follow CMS on Twitter CMS Administrator @SeemaCMS, @CMSgov, and @CMSgovPress.

Protect Yourself from Medicare Fraud

Every year, many seniors are targeted by scammers who want to steal their Medicare numbers to do things like rack up fake health care charges and commit identity theft. These scams hurt seniors and other people eligible for Medicare, cost taxpayers money, and result in higher health care costs for everyone. The good news is that you can protect yourself from fraud and help Medicare stop scammers in their tracks.

How to Spot Medicare Fraud

The first step in protecting yourself from Medicare fraud is knowing how to spot it. Over time, scammers have become very sophisticated advanced. One of the latest scams you should look out for concerns genetic testing. Scammers are offering “free” genetic tests and claiming Medicare will cover it — so they can get your Medicare number and use it to commit fraud and identity theft. Other Medicare scams include offers for free or reduced-price medical equipment, consultations, or health services. These scams can happen anywhere, including through telemarketing calls, health fairs, and even knocking on doors.

Last year, the Centers for Medicare & Medicaid Services (CMS) removed Social Security numbers from all Medicare cards. Even with this change, people with Medicare should still guard their Medicare card and treat it like a credit card, check Medicare claims summary forms for errors, and be wary of any unsolicited requests for your Medicare number. Medicare will never call beneficiaries to ask for or check Medicare numbers.

To protect yourself from Medicare fraud, keep these things to “do”:

- DO protect your Medicare number and treat your Medicare card like it’s a credit card.

- DO remember that nothing is ever “free.” Don’t accept offers of money or gifts for free medical care.

- DO review your Medicare claims for errors and problems, including things like fake charges, double billing or other fraudulent activity, waste or abuse.

- DO visit www.medicare.gov/fraud to learn more about how you can protect yourself from Medicare fraud.

- DON’T give your Medicare card or Medicare number to anyone except your doctor or people you know should have it.
- DON'T accept medical supplies, equipment, or genetic testing kits from door-to-door salesmen or solicitors at a mall or fair.

- DON'T let anyone persuade you to receive health care services you don’t need, such as genetic testing. Only make these decisions with your doctor.

**Reporting Medicare Fraud**

If you think you may have spotted fraud, you should report it right away. No matter how minimal the information you share is, it could be the missing piece to stopping the next fraud scheme. If you are a victim of fraud, know that you won’t be penalized or lose your coverage for reporting it. Even if you are not a victim, it’s important to report any fraud scams you encounter.

*Information provided by the U.S. Department of Health & Human Services.*

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**New Medicare Plan Finder**

**Top 10 Questions & Answers for those Helping People with Medicare**

1. **When will access to the current Plan Finder end?**

The old Plan Finder won’t be available once the 2020 plan preview information is launched. The timing for this is expected to be around the beginning of October 2019, as it has been in prior years. We are working to extend access to any drug lists created in the old Plan Finder through the end of the 2019 Open Enrollment.

2. **Will SHIP counselors, agents and brokers (or non-beneficiaries) be able to make a new drug list and save it?**

People who help Medicare beneficiaries compare and select plans using the Medicare Plan Finder will still be able to provide this help. The new Plan Finder still allows all users to search health and drug plans anonymously. To get the most personalized information and costs, SHIP counselors and others can help beneficiaries create and use a MyMedicare.gov account to access additional features like creating a personal drug list and accessing low-income subsidy information.

3. **How can SHIP counselors, agents and brokers (or non-beneficiaries) help beneficiaries create accounts and compare/enroll in plans without violating HIPAA requirements?**

Beneficiaries who work with trusted counselors using the old Medicare Plan Finder have always needed to share some sensitive personal information if they want help conducting a personalized search or enrolling in a plan. When using the new Plan Finder, counselors are expected to uphold the same practices they currently have in place to ensure that any personal information is kept safe and secure and is used appropriately and only for the purpose that it was offered and intended.

4. **If a beneficiary has used the Medicare Plan Finder in the past, and has an existing drug list created, will all their information carry over into the new Plan Finder?**

If someone has already created an account on MyMedicare.gov, they will use that same username and password to log into the new Plan Finder – there is no need to create another account. If they have an existing drug list stored in MyMedicare.gov, we are recommending that they print a copy of that list and use it to create an updated list in the new Plan Finder, using their old list and the suggestions pulled from their claims information. Because the previous technology is proprietary, their old drug list won’t be transferred to the new Plan Finder.
5. In the old Plan Finder, a user could sort the drug plans available in the ZIP code by total cost. This feature is not included in the new Plan Finder – will it be added?

Yes, we have always planned to include the option to sort plans based on Total Annual out-of-pocket costs by Open Enrollment, and development of that feature is on track.

6. How can I check to see if a plan offers some of the new supplemental benefits such as meal delivery? Is there a way to search for that in Plan Finder?

People with Medicare can filter plan results in the new Plan Finder on the supplemental benefits they’ve told us are most important to them: dental, vision, hearing, transportation and fitness benefits.

With the 2020 plan information that will be available in Open Enrollment, there will be an expanded list of supplemental benefits shown in the plan details and comparison. We are also exploring options for adding search capabilities for certain benefits in future years.

7. With this new Plan Finder, is Medicare trying to encourage people to stop using SHIP counselors and agents or brokers and/or force people to go online?

Plan Finder is not a replacement for our traditional customer service options, including in-person counseling from SHIPs, 1-800-MEDICARE, print materials like the Medicare & You handbook, or consultations with a trusted agent or broker. People with Medicare should feel free to use the support option they’re most comfortable with to help them understand their options and decide that best meets their needs.

These improvements to Plan Finder are one of several projects in our eMedicare initiative, which is about improving customer service – regardless of the channel -- for Medicare beneficiaries.

8. In the old Plan Finder, we could easily print reports of the comparison results and use them to help beneficiaries, as well as keeping a record for our own audit and training requirements. These reports don’t print well in the new Plan Finder, and we’ve had trouble viewing some pages on browsers other than Chrome. Are you fixing this?

Yes, we’re in the process of adjusting the printing capabilities in the new Plan Finder and expect those features to be improved soon. We’re also continuing to improve the user experience on some of the less common browsers.

9. Does the new Plan Finder include Medigap policy information in its results for Original Medicare plans?

The new Plan Finder better integrates Medigap data into the step-by-step process that users follow. As an example, someone interested in Original Medicare with additional Part D and Medigap coverage will first be taken through the Plan Finder Part D comparison and enrollment section, and then directed to the Medigap tool. In the current Plan Finder, these are separate activities.

Additionally, the Medigap tool has been redesigned and mobile optimized. Medigap plans are primarily regulated by State Departments of Insurance and are sold by private insurance companies, not CMS. As a result, CMS has limited Medigap data available and we cannot support direct online Medigap plan enrollment. The Medigap information that is included in Medicare Plan Finder is intended for general education only.

10. Will the new Plan Finder confirm a beneficiary’s current coverage and/or low-income subsidy amount?

If a beneficiary uses the Plan Finder while logged in through their MyMedicare.gov account, we will be able to show and factor in any information that Medicare has about their current enrollment and cost-savings through subsidies.

For more information about the New Medicare Plan Finder, visit www.medicare.gov.
According to CNN Health -- The aches, the sneezing, the sore throat, the exhaustion -- flu season is here, and you want to be prepared.

 Typically, the "season" starts in October, but there has already been flu-related deaths reported. Physicians say it's not too early to get a flu shot and they are available at many pharmacies and doctor's offices around the country.

 The US Centers for Disease Control and Prevention recommends that people get a flu vaccine by the end of October, if possible. Doctors say you want to have one before Thanksgiving, when you are likely to see more people, travel and be exposed to more germs. It typically takes about two weeks to build up your immunity once you get the shot.

 For the 2018-2019 US flu season, which started October 1, 2018, and ended May 4, preliminary numbers from the CDC estimate there were nearly 42.9 million cases of flu, up to 647,000 hospitalizations and up to 61,200 flu deaths.

 It wasn't a typical flu season, experts said. The severity was moderate, the CDC reported, but it was record-breaker as the longest flu season in a decade. "Last year was funny in a way," said Dr. William Schaffner, National Foundation for Infectious Diseases medical director and professor of preventive medicine at Vanderbilt University Medical Center. "We had an unprecedented event with one virus dominating the season early on, then it abated, then another strain came along, making this a double-barrel season that we hadn't seen before and also making it rather prolonged."

 Predicting the Flu This Year

 For this year, the "crystal ball is very cloudy," about how bad it will be, but flu season is "not good for anyone," Schaffner said -- especially for the very young, pregnant women, the elderly and people with chronic conditions. All are vulnerable to the worst effects of the flu.

 "One sure thing about influenza is, where and how it will spread or what kind of season we will have, it is unpredictable," said Dr. Daniel B. Jernigan, the director of the influenza division at the National Center for Immunization and Respiratory Diseases, a division of the CDC. "The more we know, the more we know you can't figure it out very well." Jernigan said the CDC has increased the number of viruses it tests for and it works with scientists from all around the world to track them. Using sophisticated artificial intelligence and modeling they can characterize where the virus is going and what kind of virus it will be to some extent. But it's not easy, since the virus changes every year as it moves through the population.

 "This virus continues to be elusive," Jernigan said. "While we don't have a clear idea, we do know flu is going to be here and the best way to prevent it is to get a vaccine." "We get on our soapbox and remind people that everyone older than 6 months needs to be vaccinated every year," said Schaffner.

 It's not a perfect vaccine because there are several flu strains that circulate, but it does provide some protection. If you happen to get sick, the vaccine cuts down on how long your symptoms last and it should protect you from the major complications that come with the flu, such as pneumonia.

 "What the vaccine does is shift the equation in our favor," said Schaffner.

 This year, nasal spray is an option for some patients, including children who may not like getting a shot. In some years, the American Academy of Pediatrics recommended children stick with a shot, as some studies showed it was more effective. There is no such suggestion this year. Schaffner adds that if you have a chronic disease such as diabetes or asthma or heart disease, the flu shot should be a part of your regular care. In that case, you are the kind of patient that the flu makes very sick and you are at highest risk for hospitalization and death. The flu can also put you more at risk to have a heart attack or a stroke.

 With some older people, doctors might recommend they get the vaccine in the middle or end of October, because their immunity could wane toward the end of the season. But Dr. David Cennimo, an infectious disease specialist and assistant professor in the department of medicine at Rutgers University, said he usually tells his patients to get it whenever they can. "If they are really concerned about the potential for the vaccine to wane over six months, they may want to wait a few weeks, but you really don't want to go beyond middle October or the end of October, because of the risk of exposure to flu in your area," said Cennimo.

 What else can you do to avoid the flu? There are ways to avoid the flu. Repeatedly washing your hands can help protect you this flu season. Flu germs tend to linger, and hand washing can cut down our exposure. Avoid friends and family members that are sick.

 And for the sake of those around you, stay home from work or school if you are sick. Rest will help you get better and staying home can protect people around you.

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