Medicare Overview

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Medicare is the government program that began in 1965 to provide medical coverage to people age 65 and older regardless of income. Throughout the years, the program has been expanded to include people under age 65 if they have qualifying disabilities. Today, more than 55 million Americans are enrolled in the Medicare program.

Medicare coverage is divided into four main parts: Part A, Part B, Part C and Part D. Parts A and B are sometimes called original Medicare and are administered by the government. Parts C and D were added later and are administered through private insurers approved by Medicare.

Part A: Hospital Benefit

Under Part A, beneficiaries are responsible for a deductible and coinsurance for certain types of inpatient stays. Part A typically covers the following:

- Hospital care
- Skilled nursing facility care
- Some nursing home care
- Hospice
- Home health services

Part B: Medical Benefit

Under Part B, beneficiaries are responsible for a deductible, and most beneficiaries pay 20 percent coinsurance for Part B services. Part B covers medications administered by a physician, like certain vaccinations or chemotherapy that are injected or infused. Part B also typically covers the following:

- Doctor visits
- Preventive care
- Lab tests, x-rays and more
- Ambulance services
- Durable medical equipment

- Mental health
  - Inpatient
  - Outpatient
  - Partial hospitalization
- Getting a second opinion before surgery
- Limited outpatient prescription drugs

Part C: Medicare Advantage

Medicare Part C – also known as Medicare Advantage – consists of health plans, such as Health Maintenance Organizations or Preferred Provider Organizations, administered by private insurers. These plans are required to cover the same services covered by Medicare Parts A and B, and some plans may cover things Medicare does not, such as dental or vision coverage. Enrollees in Medicare Advantage must already have Medicare Parts A and B. Some Medicare Advantage plans may also provide the Part D prescription drug benefit (explained in more detail below). More than 17 million beneficiaries were enrolled in Medicare Advantage plans in 2016.

Part D: Prescription Drug Benefit

Medicare Part D was created as part of the Medicare Modernization Act of 2003 and formally implemented in 2006. Part D covers outpatient prescription drugs through private plans that are approved by Medicare. These plans can be offered as stand-alone plans for beneficiaries enrolled in Part A and Part B, or combined with a Medicare Advantage plan. Beneficiaries pay monthly premiums and cost sharing for their medicines. Additional financial assistance is available to beneficiaries with modest incomes and resources through a program known as Extra Help or the low-income subsidy. About 41 million Medicare beneficiaries were enrolled in Part D as of 2016.

Medicare Enrollment & Options

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

ELIGIBILITY

To be eligible for Medicare, you must be either a U.S. citizen or a legal permanent resident for at least five continuous years. Medicare is available for people age 65 or older, younger people with disabilities and people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or ALS (Lou Gehrig's disease).

Qualifying Based on Age

If you are qualifying based on your age, you must be at least 65 years old and:

- a U.S. citizen, or
- a permanent legal resident who has lived in the U.S. for a minimum of five years before applying, or
- a green card holder who has been married to a fully insured U.S. citizen or green card holder for at least one year.

Qualifying Based on a Disability

Medicare coverage begins at the beginning of the 25th month after you began receiving Social Security disability benefits. The 24 months do not need be consecutive. For example, if you received benefits for a few months, then lost eligibility but qualified again at some later date (even years later), all the months in which you received benefits would count toward the 24-month waiting period.

The 24-month waiting period may be waived in two circumstances:

- If you have permanent kidney failure — known as end-stage renal disease (ESRD) and defined as needing regular dialysis or a kidney transplant — you may qualify for Medicare within one to three months. The start of Medicare coverage depends on what kind of care you need (dialysis or a kidney transplant) and whether you have coverage under an employer plan.
- If you have amyotrophic lateral sclerosis — known as ALS or Lou Gehrig's disease — you must apply for Social Security disability. Your Medicare coverage begins at the same time as you start receiving disability benefits (usually five months after your disability application has been approved).

Regarding additional disabilities, a person who is entitled to monthly Social Security or Railroad Retirement Board benefits is automatically entitled to Medicare Part A after receiving disability benefits for 24 months. Additionally, disabled federal, state and local government employees who are not eligible for monthly Social Security or Railroad Retirement Board benefits may get disability benefits and automatically entitled to Part A after being disabled for 29 months.

THE ENROLLMENT PROCESSES

Enrollment in Medicare can happen in a few different ways.

Automatic Enrollment

Generally, if you're receiving Social Security or Railroad Retirement Board benefits, you will be automatically enrolled in Medicare when you turn 65. If you're under 65 and have been receiving disability benefits from Social Security or the Railroad Retirement Board for two years, or if you have ALS or ESRD, you also qualify for automatic enrollment.

Initial Enrollment Period

If you do not qualify for automatic enrollment in Medicare, you need to apply when you become eligible during

the Initial Enrollment Period. This is a seven-month period that starts three months before the month of your 65th birthday, includes the month you turn 65 and ends three months after your birthday month. This period applies to benefits of original Medicare (Part A and Part B) or selection of a private plan to deliver Medicare benefits, called Medicare Advantage.

General Enrollment Period

If you did not qualify for automatic enrollment and you missed the Initial Enrollment Period, you can still enroll in Part A and Part B during the General Enrollment Period which runs from January 1 to March 31 each year. If you enroll in Medicare during the General Enrollment Period, your coverage begins in July of that same year.

Open Enrollment Period

Additions to existing plans or changes to coverage, including Part C (Medicare Advantage plans) and Part D (prescription drug coverage) can be made during the Open Enrollment Period. Medicare beneficiaries will start to receive information in October each year about changes the plans have made. These may include details such as cost, coverage and what providers and pharmacies are in their networks. Beneficiaries should carefully read this information so they can make the best decisions regarding whether or not it is in their best interest to maintain their current plan or move to a different provider to ensure their specific needs are best met.

PREMIUMS & CO-PAYMENTS

While the Medicare program provides healthcare coverage, there are some out-of-pocket costs to consider and there are instances where you are responsible for paying for a share of your health coverage. Whether you're talking about Original Medicare (Part A and Part B), or private insurance options provided through Part C (Medicare Advantage) Part D (drug coverage), it is important to understand the costs that you are responsible for covering as a beneficiary.

2017 COST AT A GLANCE	
Part A premium	Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $413. if you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $227.
Part A hospital inpatient deductible and coinsurance	You Pay: • $1,316 deductible for each benefit period • Days 1-60: $0 coinsurance for each benefit period • Days 60-90: $329 coinsurance per day for each benefit period • Daya 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: all costs
Part B premium	The standard Part B premium amount is $134 (or higher depending on your income). However, most people who get Social Security benefits will pay less than this amount ($109 on average)
Part B deductible and coinsurance	$183 per year. After your deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment.
Part C premium	Part C monthly premium varies by plan
Part D premium	The Part D monthly premium varies by plan (higher-income consumers my pay more).

There are also additional costs to consider that a beneficiary is responsible for covering. These include the following:

- Deductible – the amount you must pay for healthcare or prescriptions before Medicare begins to pay its share
- Co-Insurance – the amount you may be required to pay for services after you pay any deductibles, as a percentage of the cost of the service or item.
- Co-Payment – the fixed dollar amount you pay for each medical service, such as a doctor's visit, or prescription

INFORMATION AND ASSISTANCE NAVIGATING THE MEDICARE PROCESS

The Medicare eligibility and enrollment processes can sometimes be difficult to navigate due to the amount of information and options to consider. To help beneficiaries work through it all, there are trusted resources available to assist in providing the help many individuals need in ensuring they have a full understanding of what is available to them.

State Health Insurance Assistance Programs (SHIPs)

The State Health Insurance Assistance Programs (SHIPs) provide free, in depth, one-on-one insurance counseling and assistance to Medicare beneficiaries, their families, friends, and caregivers. SHIPs operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

SHIPs answer questions about Medicare and assist people in obtaining coverage through options that include the Original Medicare program (Part A and Part B), Medicare Advantage (Part C) Plans, Medicare Prescription Drug (Part D) Plans, and programs designed to help people with limited incomes pay for their healthcare, such as Medicaid, the Medicare Savings Program, and the Low Income Subsidy. SHIPs also help people compare Medicare Supplemental insurance policies (Medigap) and explain how they work with Medicare. In addition, SHIPs provide information on long-term care insurance and, when needed, refer beneficiaries to agencies such as the Social Security Administration and local Medicaid offices for additional assistance.

Area Agencies on Aging (AAA)

Area Agencies on Aging (AAAs) were established to help Americans 60 and over in communities across the country. By providing seniors with a range of community-based services options and services that suit them best, AAAs make it possible for older adults to "age in place" in their homes and communities. They also work in helping older adults with Medicare enrollment through one-on-one counseling, assistance in selecting a Medicare Part D prescription drug plan, and outreach to low-income beneficiaries not yet enrolled in money-saving programs.

Medicare Plan Finder

To help you navigate your plan options, Medicare.gov offers a Plan Finder that allows you to search based on region and your specific coverage needs, including the specific prescription medications you take. This useful tool will help you sort through the various plans to ensure your selections best meet your needs.

Financial Assistance for Medicare

Sometimes Medicare beneficiaries need assistance in paying costs associated with their coverage and overall healthcare needs. There are programs available to help individuals who meet the qualifications.

If a beneficiary meets certain income and resource limits, they may qualify for a Medicare program available to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance. Other people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level.

Even if someone doesn't qualify for Extra Help, their state may have programs that can help pay their prescription drug costs. They should contact their state's Medicaid office or their State Health Insurance Assistance Program (SHIP) for more information. Extra help can be applied for at any time if income or resources change.

Some people automatically qualify for Extra Help if they have Medicare and meet any of the following conditions:

- Have full Medicaid coverage
- Get help from their state Medicaid program paying Part B premiums (in a Medicare Savings Programs)
- Get Supplemental Security Income (SSI) benefits

Additional programs available to qualifying individuals include the following:

Programs of All-Inclusive Care for the Elderly (PACE)

Programs of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their healthcare needs in the community instead of going to a nursing home or other care facility. PACE organizations have contracts with specialists and providers in the community to provide care and services to those who need them. Depending on whether an individual has Medicaid or Medicare, beneficiaries may have to pay a premium for some services.

PACE provides all the care and services covered by Medicare and Medicaid if authorized by the beneficiary's healthcare team, and may cover others deemed necessary that fall outside the scope of both programs.

Services covered by PACE include:

- Adult day primary care
- Dentistry
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Medical specialty services
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Physical therapy
- Prescription drugs

Medicare Savings Programs

There are assistance programs that can help you pay for your Medicare premiums. These programs, each with their own eligibility requirements and income limits, can help with costs associated with Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments.

- The Qualified Medicare Beneficiary (QMB) Program helps pay for the following:
  - Part A premiums
  - Part B premiums
  - Deductibles, coinsurance, and copayments
- Specified Low-Income Medicare Beneficiary (SLMB) Program helps pay for the following:
  - Part B premiums only

- Qualifying Individual (QI) Program helps pay for the following:
  - Part B premiums only
- Qualified Disabled and Working Individuals (QDWI) Program helps pay for the following:
  - Part A premiums only

To see if you qualify for any of the Medicare Savings Programs listed above, contact your state's Medicaid Program Office or consult with experts at SHIP who can aid in navigating the application process.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. It is possible to be eligible for both Medicare and Medicaid and the two programs can work hand in hand. There may also be ways to qualify for Medicaid even if an individual's income exceeds their state's income levels by being deemed "medically needy".

Each state has different eligibility requirements so it is best to connect with your state's Medicaid Program Office to determine if you qualify for this assistance.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a cash benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are intended to help people meet basic needs for food, clothing, and shelter, and are not the same as Social Security benefits.

To see if you qualify for SSI assistance, visit benefits.gov/ssa, and use the "Benefit Eligibility Screening Tool". You may also call Social Security at 1-800-772-1213 or contact your local Social Security office for more information.

TYPES OF MEDICARE COVERAGE

Part A and Part B (Original Medicare)

Original Medicare, divided into Part A (hospital benefits) and Part B (medical insurance), is administered by the federal government and is available to American citizens and permanent residents 65 years of age or older. Others may qualify before this age due to end-stage renal disease (ESRD), amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease), or of they've received certain disability benefits for two years or more from the Social Security Administration or the Railroad Retirement Board.

Beneficiaries choosing to access their Medicare services through Original Medicare can go to any doctor, other healthcare provider, hospital, or other facility that's enrolled in Medicare and is accepting new Medicare patients.

- Part A
  - Medicare Part A helps pay for the costs of inpatient care in the hospital and short-term skilled nursing facilities. It also pays for some home health services and hospice care, if the conditions for coverage are met.
- Part B
  - Medicare Part B covers doctor appointments, outpatient care and medications that are administered by a physician. These medications, many of which are administered via injection or an IV infusion, are typically used to treat complex and serious conditions like cancer, arthritis or immune disorders.

Part C (Medicare Advantage)

Medicare Advantage plans are administered by private insurance companies that contract with Medicare and include services of Part A and Part B. These plans may also cover outpatient prescription drugs (Part D).

You can sign up for a Medicare Advantage plan when you're first eligible for Medicare or during the annual Open Enrollment Period (Oct. 15 – Dec. 7). Beneficiaries enrolled in a Medicare Advantage plan pay a monthly premium for their coverage and out of pocket copayments, coinsurances, and deductibles continue to apply as well.

Beneficiaries choosing to access their Medicare services through a Medicare Advantage plan need to use doctors, hospitals, and other providers considered in-network to their specific plan or they pay more or all the costs.

Part D (Prescription Drug Coverage)

Medicare Part D, which began in 2006, added outpatient prescription drug coverage to the Medicare program. Unlike Medicare Parts A and B which are directly administered by the federal government to beneficiaries, Part D coverage is provided by private insurance companies, though the government has oversight over the program. Medicare beneficiaries must opt in for Part D coverage and can choose or change plans each year during the Open Enrollment Period (Oct. 15 – Dec 7). During this time, beneficiaries compare the plans available in their state and choose the coverage that best fits their specific health and financial needs. This open marketplace creates competition between plans and incentives for insurers to keep coverage broad and prices low. These savings can be passed to beneficiaries in the form of lower copays, deductibles or premiums in their Part D plans. CMS reviews and approves these plans and generates a national average bid amount. Individual plan premiums are determined by comparing each plan's bid to the national average bid.

Medigap

Medigap is Medicare supplemental insurance. Sold by private insurance companies, they can help pay some of the healthcare costs ("gaps") Original Medicare doesn't cover, such as Medicare deductibles, coinsurance and some extra benefits such as care when you travel outside the U.S.

To buy a Medigap policy you must access Medicare benefits through Original Medicare, not Medicare Advantage. It is also important to know that a Medigap policy only covers the individual (not a spouse), so if both want this supplemental coverage, separate policies must be purchased.

Medicare Costs

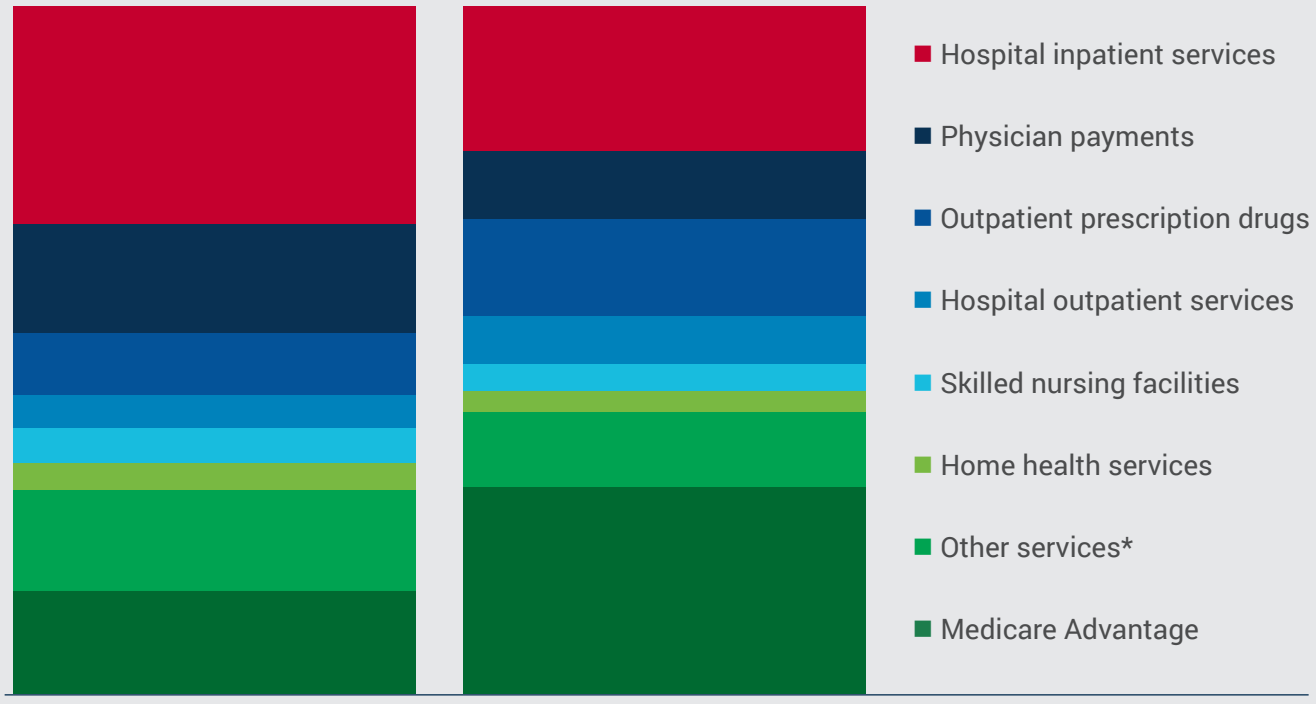
COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Since Medicare Part D was first implemented in 2006, the benefits to Medicare beneficiaries have been evident. The American Journal of Managed Care found that almost 200,000 Medicare beneficiaries have lived at least one year longer and life expectancy for them has increased by 3.3 years, thanks to better health and slower disease progression. These improvements in health have resulted in fewer hospitalizations and reduced nondrug medical spending, leading to a reduction in overall health care spending.

In August 2017, the Centers for Medicare & Medicaid Services (CMS) announced that Medicare Part D prescription drug plan premiums are projected to drop. CMS estimates the average monthly Part D premium in 2018 will be $33.50, about a dollar less than this year's average. These savings to taxpayers are achieved through privately negotiated discounts that have resulted in Part D costs being half of what was projected for the program.

The chart below demonstrates the differences in Medicare costs since 2006 and partly reflects the impact of Part D benefit on the composition of Medicare spending, including a reduced portion of each dollar on hospitalizations.

MEDICARE BENEFIT PAYMENTS BY TYPE OF SERVICE — 2006 AND 2016



2006
Total benefit payments: $375 billion

2016
Total benefit payments: $675 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services. SOURCE: Congressional Budget Office, June 2017 Medicare Baseline.

Medicare FAQ's

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Q: What is Medicare?
A: Medicare is a federal health insurance program for people who are age 65 and over and for those younger who qualify due to a disability, end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or ALS (Lou Gehrig's disease).

Q: What are the various parts of Medicare?
A: Medicare has four parts, each offering a different type of coverage: Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage—Parts A and B benefits administered by a private health plan) and Part D (prescription drug coverage).

Q: What is the difference between Medicare and Medicaid?
A: Medicare is a federal health insurance program for people age 65 and over and younger people who qualify due to a disability. Medicaid is a state-run program that provides health coverage for people with low incomes, regardless of age. It is possible to qualify for both.

Q: How do I qualify for Medicare?
A: You can qualify for Medicare two ways. First, Individuals become eligible for Medicare when they turn 65. Individuals may also become eligible at a younger age due to a disability, a diagnosis of end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease).

Q: Do I automatically receive Medicare when I turn 65?
A: Some Medicare enrollments are automatic (if you're receiving Social Security or Railroad Retirement Board benefits, or have ESRD or ALS) but most are not. If you do not qualify for automatic enrollment in Medicare, you need to apply when you become eligible or during one of the various enrollment periods. It depends on your specific circumstance. You may visit www.ssa.gov or call Social Security at 800-772-1213 for more information.

Q: How do I enroll in Medicare?
A: You can apply for Medicare online, by phone or in person. You can file for Medicare online at www.ssa.gov when you file for Social Security retirement benefits or If you prefer to apply in person, you can make an appointment by calling Social Security at 800-772-1213. If you are already receiving Social Security benefits, you will automatically be enrolled in Medicare parts A and B. However, because you must pay a premium for Part B coverage, you have the option of turning it down. You will be contacted by mail a few months before you become eligible and given all the information you need.

Q: The Medicare eligibility and enrollment processes can be confusing to navigate. Is help available to me?
A: The Medicare eligibility and enrollment processes can sometimes be difficult to navigate due to the amount of information and options to consider. There are trusted resources available to help individuals ensure they have a full understanding of what is available to them. These include the following:

- State Health Insurance Assistance Programs (SHIPs)
- Area Agencies on Aging (AAA)
- Medicare.gov's Plan Finder

Q: Original Medicare is comprised of Part A and Part B, but what does that cover?
A: Under Part A, beneficiaries are responsible for a deductible and coinsurance for certain types of inpatient stays. Part A typically covers the following:

- Hospital care
- Skilled nursing facility care
- Some nursing home care
- Hospice
- Home health services

Under Part B, beneficiaries are responsible for a deductible, and most beneficiaries pay 20 percent coinsurance for Part B services. Part B covers medications administered by a physician, like certain vaccinations or chemotherapy that are injected or infused. Part B also typically covers the following:

- Doctor visits
- Preventive care
- Lab tests, x-rays and more
- Ambulance services
- Durable medical equipment
- Mental health
  - Inpatient
  - Outpatient
  - Partial hospitalization
- Getting a second opinion before surgery
- Limited outpatient prescription drugs

Q: What is Medicare Advantage?
A: While Medicare Parts A and B are administered by the federal government, beneficiaries can opt to receive their benefits through Part C (Medicare Advantage). These plans are run by private insurance companies and are required to offer, at a minimum, the same coverage benefits as Parts A and B. Some Medicare Advantage plans may also provide prescription drug coverage or additional benefits like dental or vision. Beneficiaries who choose a Medicare Advantage plan must see physicians and visit healthcare facilities considered in-network to their specific plan or pay for the full costs associated with that physician or service.

Q: How do I find out what Medicare Advantage plans are available to me?
A: Medicare Advantage plan offerings vary by region. To see what is available to you, visit www.medicare.gov/find-a-plan.

Q: Are my prescription drugs covered by Medicare?
A: Individuals may choose to enroll in Medicare Part D, which covers outpatient prescription drugs through private plans that are approved by Medicare. These plans can be offered as stand-alone plans for beneficiaries enrolled in Part A and Part B, or combined with a Medicare Advantage plan. Individuals can search Part D plan

options to see which plans cover their medications and find a plan that best meets their needs.

Q: How much does Medicare Part D cost?
A: The Part D plans set their own cost structures, and they vary from plan to plan. Beneficiaries pay monthly premiums and cost sharing for their medicines. It is best to find out what plan options are available to you to determine what they may cost you. It is important to note that the Extra Help program is available to help those with lower income levels.

Q: Does Medicare cover all my healthcare costs?
A: Medicare does not cover all your healthcare costs. You are required to pay premiums, deductibles and copays or coinsurance, which vary according to the type of Medicare coverage you choose and, in some cases, your income.

Q: What are the costs associated with Medicare that I am responsible for?
A: There are some costs that the beneficiary is responsible to pay for once they are covered by Medicare. These include:

- Premium – the monthly amount you pay to Medicare or a private insurance plan for your healthcare and/or your prescription drug coverage.
- Deductible – the amount you must pay for healthcare or prescriptions before Medicare begins to pay its share.
- Co-Insurance – the amount you may be required to pay for services after you pay any deductibles, as a percentage of the cost of the service or item.
- Co-Payment – the fixed dollar amount you pay for each medical service, such as a doctor's visit, or prescription.

Q: Can I buy supplemental insurance such as Medigap?
A: Yes, you have the right to buy any Medicare supplemental insurance policy available where you live during the six months after you turn 65 and first enroll in Medicare Part A and Part B. You may not be able to purchase it after this period ends or a company may charge you a higher premium based on your health if you miss this window. It's also important to note that Medigap policies are not available to those choosing a Medicare Advantage plan and Medigap does not provide supplemental coverage insurance for Part D prescription drug coverage.

Q: What resources are available to me if I need help paying for my Medicare costs?
A: There are several resources available to Medicare beneficiaries who qualify for them, usually based on income level and/or resources. The Medicare Savings Program helps with these costs and can be contacted by calling 800-633-4227 or visiting www.medicare.gov. Assistance specific to Part D is also available through the Low Income Subsidy (Extra Help Program). Local SHIPs and Area Agencies on Aging can help in identifying these assistance programs and provide guidance on qualifications for each.

Q: How can I protect myself from Medicare fraud?
A: It is important to keep your information safe. Don't give your information to anyone who comes to your home (or calls you) uninvited, selling Medicare-related products. Only give personal information when you have initiated the contact with a plan. For example, you call or visit the websites of plans that are approved by Medicare. Call 1-800-MEDICARE if you aren't sure if a plan is approved by Medicare.

Straight from Seniors

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

"As a retired person, Medicare is critically important to my life and well-being. I love the ease of access and the confidence it gives me as I go for health checkups and services." – *Theodore D., Alabama*

"In the five years I have been on Medicare, I have been able to continue accessing the doctors and healthcare facilities that I've come to trust over the years. Maintaining my health is a priority, and Medicare helps me to do that." – *Margarita M., Florida*

"When I switched from private insurance through my employer to Medicare, I wanted to make sure I had the same coverage. My Medicare coverage is even better than my old insurance. A few years ago, I was diagnosed with cancer and had to have major surgery. Medicare covered my hospitalization, post-operative care, and importantly all of the medications that I needed. Thanks to my Medicare coverage, I was able to obtain the treatments that made me healthy again and cancer-free." – *Carol K., New York*

"Here's what I appreciate about Medicare. The program works just like we were told it was going to. I fulfilled my obligation and paid into the system from the time I started working. And when I enrolled, the program fulfilled its obligations and is providing me with affordable healthcare coverage just like I expected it to." – *Mardele C., Ohio*

"I had my employer-provided insurance for many years before I turned 65, and when I was finally able to switch to Medicare, I wasn't sure what to expect. I was pleased to see that through my Medicare Advantage plan I was still able to see the doctors I had been seeing and receive the great care I'd come to appreciate – all at a lower premium than I'd been paying!" – *Fred S., Florida*

"I was pleased to see that through my Medicare Advantage plan I was still able to see the doctors I had been seeing and receive the great care I'd come to appreciate – all at a lower premium than I'd been paying!"

"Medicare allows me to maintain relationships with the physicians and providers I know and trust. I can also access the medications I need to manage my health. Thanks to Medicare, I don't have to worry about affording quality care and treatments, even as I get older." – *Charles K., Kentucky*

"I live in a rural area where there aren't a lot of doctors. Medicare lets me choose the doctors I need. I have my family doctor here and have access to specialists elsewhere, like my cardiologist in Columbus. The same applies to my pharmacy. With Medicare Part D, I can pick which plan I need and which pharmacy I trust. That's important to me." – *Frederick S., Ohio*

"I like that Medicare offers more than enough options to find what fits. My wife and I are fairly new to Medicare, and we don't have a lot of health care needs. We do have some prescriptions though, and we tend to see our doctors more than once a year. On that note, our doctors were a great help in figuring out what kinds of plans we needed to look for, because there are a lot of options to choose from and at first it was a little intimidating. Our plans have been a good fit so far; but it's good to know though that, if our health changes, we have the option to find a new plan during the open enrollment periods each year. I worked for one of the largest corporations in the U.S. for my entire career, and the coverage I have now through Medicare beats what I had before I retired." – *Michael S., Tennessee*

Medicare Glossary of Terms

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Area Agencies on Aging (AAAs):
Program established under the Older Americans Act in 1973 to respond to the needs of Americans age 60 and over in every local community. AAAs provide a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best.

Annual Open Enrollment Period:
A roughly two-month period each fall (October 15-December 7) when eligible beneficiaries can enroll in Medicare for the first time, change their existing coverage or add Medicare Advantage or a prescription drug plan to their coverage.

Beneficiary:
A Medicare enrollee. To qualify for Medicare, people must be 65 or older or have received Social Security disability benefits for two years or more.

Carrier:
A private insurance company that processes Medicare claims.

Centers for Medicare & Medicaid Services (CMS):
The federal agency within the Department of Health and Human Services that administers Medicare, Medicaid and several other health-related programs.

Coinsurance:
A percentage of the cost of healthcare services or prescription drugs for which the beneficiary is responsible for paying out of pocket. This is a form of cost sharing.

Copayment:
A flat rate paid by beneficiaries out of pocket for medical visits, prescription drugs and other procedures. This is a form of cost sharing.

Cost Sharing:
The amount beneficiaries pay out of pocket for healthcare. Coinsurance, copayments and deductibles are common forms of cost sharing.

Coverage Gap (donut hole):
For Medicare Part D recipients, this is a gap in prescription drug coverage after the initial coverage limit has been reached, before the *catastrophic coverage kicks in where beneficiaries are responsible for lower cost sharing. Since 2011, beneficiaries receive a 50 percent discount on brand drugs while in the coverage gap, and more generous plan coverage is phasing in for brand and generic medicines such that the coverage gap will be closed for beneficiaries by 2020. Consult the following resource to calculate your costs: https://q1medicare.com/PartD-DonutHole-CoverageGap-Calculator.php

* Catastrophic coverage refers to the point when a beneficiary has spent $4,950 out-of-pocket in 2017, and is now out of the coverage gap. Once out of the coverage gap (Medicare prescription drug coverage), the beneficiary automatically gets "catastrophic coverage." It assures they only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

[1] https://www.careplushealthplans.com/medicare-information/glossary
[2] https://www.careplushealthplans.com/medicare-information/glossary
[3] https://www.careplushealthplans.com/medicare-information/glossary and https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[4] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[5] https://www.careplushealthplans.com/medicare-information/glossary
[6] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP

Deductible:
The amount a beneficiary must pay for healthcare or prescriptions out of pocket before an insurance plan kicks in. This is a form of cost sharing.

Dual Eligible:
A beneficiary who is eligible for medical benefits under both the Medicare and Medicaid programs.

Evidence of Coverage (EOC):
A document issued to new members of a health plan or renewing members of a health plan annually that certifies enrollment in a plan and describes that plan's benefits. It is good to keep this documentation in a safe place.

Formulary:
The list of prescription drugs covered by a Medicare Part D or Medicare Advantage prescription drug plan. This list does not remain constant and is subject to change each year, although mid-year changes are limited and a beneficiary will be notified.

Health Maintenance Organization (HMO):
A type of insurance plan offered to Medicare Advantage beneficiaries that offers coverage of the services provided within the HMO network. Beneficiaries typically see a primary care physician who refers patients to specialists when needed. HMOs typically restrict enrollees' choices of hospitals and physicians to a greater extent than Preferred Provider Organizations (PPOs).

Initial Enrollment Period:
This is when a beneficiary is first eligible to enroll in Medicare –three months before and after a beneficiary's 65th birthday month. If the beneficiary doesn't enroll in Medicare during this period and is not covered by an employer's or spouse's insurance, the individual faces an added penalty if he or she enrolls in Medicare at a later date.

Late Enrollment Penalty:
A fee added to beneficiaries' premiums if they did not enroll in Medicare during their Initial Enrollment Period, or if they allowed their insurance coverage to lapse.

Low-Income Subsidy or Extra Help:
This program provides financial assistance to beneficiaries with modest income and resources by reducing or eliminating their premiums and out-of-pocket prescription drug costs. Visit the following link to learn if you qualify for assistance: https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html.

Medicaid:
A partnership between the federal government and states that provides healthcare to people with low incomes (who may also be covered by Medicare) and those with disabilities.

Medicare Modernization Act of 2003 (MMA):
A law passed in 2003 that added outpatient prescription drug benefits (Part D) to Medicare and established the average sales price system for Part B medicines.

[7] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[8] https://www.careplushealthplans.com/medicare-information/glossary
[9] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[10] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[11] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[12] https://medicare.kaiserpermanente.org/wps/portal/medicare/plans/links-help/glossary and http://www.aarp.org/health/medicare-insurance/info-05-2009/ask_ms_medicare_question_55.html
[13] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[14] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html

Medicare Part A:
Covers inpatient hospital care, skilled nursing facilities, hospice and other home health visits.

Medicare Part B:
Covers physician visits, preventive services, tests like x-rays, other outpatient care and medicines, such as chemotherapy, that must be administered under physician supervision at a doctor's office, clinic or hospital outpatient department.

Medicare Part C (Medicare Advantage):
Offers benefits covered by Parts A, B, and typically D, as well as supplementary dental and vision benefits, through federally subsidized private insurance plans.

Medicare Part D (Prescription Drug Benefit):
Offers outpatient prescription drug coverage through federally subsidized private insurance plans.

Medigap Plans:
Private insurance plans that supplement traditional Medicare (Parts A and B) and other associated costs.

Original Medicare (Traditional Medicare):
This refers to Medicare Parts A and B.

Out-of-Network Provider:
A healthcare provider who is not covered by an insurance plan. Some insurance plans will pay for out-of-network providers, but require beneficiaries to pay a higher share of the cost. Other plans will not pay for out-of-network providers, requiring beneficiaries to pay 100 percent of the cost out of pocket.

Point-of-Service Option (POS):
Under this plan option, beneficiaries of HMOs can use doctors and hospitals outside of the plan's network at an additional cost.

Preferred Provider Organization Plan (PPO):
A type of Medicare Advantage plan that allows beneficiaries to receive care from any in- or out-of-network provider or facility. Out-of-network care generally involves higher out-of-pocket costs.

Premium:
A monthly fee paid by beneficiaries to insurers for coverage. Premiums do not count toward deductibles or out-of-pocket maximums.

Prior Authorization:
Some plans require beneficiaries or, more commonly, their physicians to seek prior approval in order to prescribe a specific treatment. These plans will not pay for services if prior approval is not secured.

[15] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[16] https://www.medicareinteractive.org/get-answers/introduction-to-medicare/explaining-medicare/what-does-medicare-cover-parts-a-b-c-and-d
[17] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[18] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[19] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[20] https://www.washingtonpost.com/national/health-science/if- you-find- medicare-sign- up-rules- confusing-read-this/2014/10/06/e525ccbe-3472- 11e4-8f02- 03c644b2d7d0_story.html?utm_term=.df08c9796989
[21] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[22] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[23] https://www.humana.com/individual-and-family/products-and-services/medical-plans/what-is-ppo
[24] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[25] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html

Private Fee-for-Service Plan (PFFS):
Offered by a private insurance company, a PFFS plan sets reimbursements and cost-sharing requirements that may differ from Medicare's rates.

Referral:
Some plans, especially HMOs, require beneficiaries to receive a written note from their primary care physician before seeing a specialist.

Special Election/Enrollment Period:
A period in which a beneficiary can change his/her current plan outside of the initial enrollment or annual open enrollment period. These enrollment periods are options when certain events happen in a beneficiary's life, such as moving or losing other insurance coverage. Rules about when a beneficiary can make changes and the type of changes possible are different for each special enrollment period.

Special Needs Plan:
A Medicare Advantage plan that is only open to enrollment for certain types of beneficiaries, such as those with chronic conditions, those who are dually eligible for both Medicare and Medicaid and those who are institutionalized.

State Health Insurance Assistance Program (SHIP):
Beneficiaries can use this program to receive one-on-one counseling about their Medicare benefits and making plan selections each year.

State Pharmacy Assistance Program (SPAP):
Subsidized by states, this program helps to pay for some prescription drug costs.

Step Therapy:
A restriction in which a health plan requires the patient to try a less expensive drug or treatment before it will cover the cost of a more expensive one.

Supplementary Security Income (SSI):
Provides support for people with low incomes who are 65 and older or who are disabled. If beneficiaries qualify for SSI, they also qualify for Part D's Extra Help program.

Tiers:
Insurance plans can place different drugs on different formulary tiers, where the tiers represent the varying levels of cost sharing. The lowest tier may require no or a small copay. The highest tier may require higher cost sharing such as coinsurance. Insurers use tiers to steer patients toward lower cost medications.

[26] https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/private-fee-for-service-plans.html
[27] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[28] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[29] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[30] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[31] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[32] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[33] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[34] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html