Getting Medicare Late Can Mean Lifetime Premium Penalties And Delays In When Your Coverage Can Start

See Page 10

Medicare

Health Insurance

The 5 Key Pieces to the Medicare Puzzle- Solved

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01 DO I HAVE TO SIGN UP FOR MEDICARE?

Medicare is health insurance for people 65 or older, certain people under 65 with disabilities, and people of any age with End-Stage Renal Disease (ESRD).
Your first chance to get Medicare usually starts 3 months before you turn 65 and ends 3 months after you turn 65. But there are other SEP's (Special Enrollment Periods) when you can enroll as well.

You can only enroll in Medicare at certain times, and the cost can go up the longer you wait to sign up. **Getting Medicare late can mean lifetime premium penalties and delays in when your coverage can start.** **See Page 10*
Deciding to enroll in Part B is an important decision. It depends on the type of coverage you have now, and whether you can sign up later (without a penalty). Not all other health coverage is the same as Part B.
If you're getting benefits from the Railroad Retirement Board (RRB), you'll get Medicare Part A and Part B automatically when you're First eligible.

02 HOW DO I SIGN UP?

The easiest way is to go online. The Social Security web site, **SSA.GOV,** has a specific area to sign up for Medicare. You will have to set up A Social Security account to do it and that's actually a good idea. Better you set it up than having somebody else with bad intentions do it for you if you get what I mean. You can always do it the old-fashioned way and go to your local Social Security office.

03 WHAT AM I ENTITLED TO?

Medicare provides **Hospital (A)** and **Medical (B)** coverage. There are also **Parts C and D** and we'll cover them later. The **Medicare Entitlement** that the government is providing are Parts A and B.

OK, SO WHAT DO I GET?

HOSPITAL PART A

Medicare Part A (Hospital Insurance) covers inpatient hospital care when all of these are true:

- You're admitted to the hospital as an inpatient after an official doctor's order, which says you need inpatient hospital care to treat your illness or injury.
- The hospital accepts Medicare.
- In certain cases, the Utilization Review Committee of the hospital approves your stay while you're in the hospital. **Skilled Nursing Care** provided in a SNF in certain conditions for a limited time (on a short-term basis) if all of these conditions are met:
- You have Part A and have days left in your benefit period to use.
- You have a qualifying hospital stay .
- Your doctor has decided that you need daily skilled care. It must be given by, or under the supervision of, skilled nursing or therapy staff.
- You get these skilled services in a SNF that's certified by Medicare.
- You need these skilled services for a medical condition that's either:
  A hospital-related medical condition treated during your qualifying 3-day inpatient hospital stay, even if it wasn't the reason you were admitted to the hospital.
  A condition that started while you were getting care in the SNF for a hospital-related medical condition (for example, if you develop an infection that requires IV antibiotics while you're getting SNF care)

LONG TERM CARE

Medicare Part A (Hospital Insurance) covers the cost of long-term care in a long-term care hospital (LTCH).

*You don't have to pay a deductible for care you get in the LTCH if you were already charged a deductible for care you got in a prior hospitalization within the same benefit period. This is because your benefit period starts on day one of your prior hospital stay, and that stay counts towards your deductible. For example:

- You're transferred to a LTCH directly from an acute care hospital.
- You're admitted to a LTCH within 60 days of being discharged from a hospital.

LTCHs specialize in treating patients that are hospitalized for more than 25 days. Patients may include people who've used ventilators for an extended period of time, or experience a severe wound or head injury.

After being discharged from the LTCH, many people get one of these:

- Care in a Skilled Nursing Facility
- Custodial care in a long-term care facility

MEDICAL PART B

Part B services are services associated outside of an In-Patient Hospital Stay and are of 2 types

1. **Medically necessary services:** Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
2. **Preventive services:** Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

   Additional services include-

   Clinical research

   Ambulance services

   Durable medical equipment (DME)

   Mental health
   - Inpatient
   - Outpatient
   - Partial hospitalization

   Limited outpatient prescription drugs

Talk to your doctor or other health care provider about why you need certain services or supplies. Ask if Medicare will cover them. You may need something that's usually covered but your provider thinks that Medicare won't cover it in your situation. If so, you'll have to read and sign a notice. The notice says that you may have to pay for the item, service, or supply.

Medicare coverage is based on 3 main factors

1. Federal and state laws.
2. National coverage decisions made by Medicare about whether something is covered.
3. Local coverage decisions made by companies in each state that process claims for Medicare. These companies decide whether something is medically necessary and should be covered in their area.

04 HOW MUCH DOES IT COST?

HOSPITAL PART A

You usually don't pay a monthly premium for Medicare Part A (Hospital Insurance) coverage if you or your spouse paid Medicare taxes for 40 Quarters while working. This is sometimes called "premium-free Part A."

Most people get premium-free Part A.

You can get premium-free Part A at 65 if:
•You already get retirement benefits from Social Security or the Railroad Retirement Board.
•You're eligible to get Social Security or Railroad benefits but haven't filed for them yet.
•You or your spouse had Medicare-covered government employment.
If you're under 65, you can get premium-free Part A if:
•You got Social Security or Railroad Retirement Board disability benefits for 24 months.
•You have End-Stage Renal Disease (ESRD) and meet certain requirements.

If you don't qualify for premium-free Part A, you can buy Part A. If you buy Part A, you'll pay up to $506 each month. If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $506. If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $278.

In most cases, if you choose to buy Part A, you must also:

- Have Medicare Part B (Medical Insurance)
- Pay monthly premiums for both Part A and Part B

BUT WHAT DO I PAY If I'M ADMITTED TO THE HOSPITAL?

	You pay:
Part A hospital inpatient deductible and coinsurance	•$1,600 deductible for each benefit period
	•Days 1-60: $0 coinsurance for each benefit period
	•Days 61-90: $400 coinsurance per day of each benefit period
	•Days 91 and beyond: $800 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

MEDICAL PART B

Your Part B Base Premium for 2023 is $164.90 per month.
Some individuals may pay more depending upon their income.

IF I USE PART B COVERED SERVICES, HOW MUCH DO I PAY?

In 2023, you pay $226 for your Part B deductible. After you meet your deductible for the year, you typically pay 20% of the Medicare-approved amount for these:

- Most doctor services
  (including most doctor services while you're a hospital inpatient)
- Outpatient therapy
- Durable medical equipment (DME)

A SPECIAL NOTE ABOUT COSTS-

There is **No Cap on the amount** that you can spend with both Medicare Parts A and B. Nope, you won't be getting that special phone call from Medicare saying something like, "We know you're not feeling well and you've spent a lot of money. Don't worry, we've got this. Your good."

05 WHAT INSURANCE CAN I GET TO HELP COVER THESE COSTS?

Well, that depends upon your individual health circumstances and there are several options available that will help pay for your cost responsibilities under Medicare and help **cap your costs.**

MEDICARE PART C-

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are an "all in one" alternative to Original Medicare. They are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. These "bundled" plans include Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), and usually Medicare prescription drug (Part D).

Medicare Advantage Plans cover all Medicare services. Some Medicare Advantage Plans also offer extra coverage, like vision, hearing and dental coverage.

Medicare pays a fixed amount for your care each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare.

Each Medicare Advantage Plan can charge different out-of-pocket costs. They can also have different rules for how you get services, like:

- Whether you need a referral to see a specialist
- If you have to go to doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care

These rules can change each year.

Your out-of-pocket costs in a Medicare Advantage Plan (Part C) depend on:

- Whether the plan charges a monthly premium . Some plans have no premium.
- Whether the plan has a yearly deductible or any additional deductibles.
- How much you pay for each visit or service (copayment or coinsurance). For example, the plan may charge a copayment, like $10 or $20 every time you see a doctor. These amounts can be different than those under Original Medicare
- The type of health care services you need and how often you get them.
- Whether you go to a doctor or supplier who accepts assignment if:
  - You're in a PPO, PFFS, or MSA plan.
  - You go out-of-network .
- Whether you follow the plan's rules, like using network providers.
- Whether you need extra benefits and if the plan charges for it.
- The plan's yearly limit on your out-of-pocket costs for all medical services.
- Whether you have Medicaid or get help from your state.

MEDICARE SUPPLEMENT PLANS- MEDIGAP-

Medigap is Medicare Supplement Insurance that helps fill "gaps" in Original Medicare and is sold by private companies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. A Medicare Supplement Insurance (Medigap) policy can help pay some of the remaining health care costs, like:

- Copayments
- Coinsurance
- Deductibles

Some Medigap policies also cover services that Original Medicare doesn't cover, like medical care **when you travel outside the U.S.** If you have Original Medicare and you buy a Medigap policy, here's what happens:

- Medicare will pay its share of the Medicare-approved amount for covered health care costs.
- Then, your Medigap policy pays its share.

7 Things to know about Medigap policies

01. You must have Medicare **Part A and Part B.**
02. A Medigap policy is different from a Medicare Advantage Plan. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.
03. You pay the private insurance company a monthly premium for your Medigap policy. You pay this monthly premium in addition to the monthly Part B premium that you pay to Medicare.
04. A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you'll each have to buy separate policies.
05. You can buy a Medigap policy from any insurance company that's licensed in your state to sell one.
06. Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you pay the premium.
07. Some Medigap policies sold in the past cover prescription drugs. But, Medigap policies sold after January 1, 2006 aren't allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare **Prescription Drug Plan (Part D).**

Medigap policies don't cover everything

Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Some types of insurance aren't Medigap plans, they include:

- Medicare Advantage Plans (like an HMO, PPO, or Private Fee-for-Service Plan)
- Medicare Prescription Drug Plans
- Medicaid
- Employer or union plans, including the Federal Employees Health Benefits Program (FEHBP)
- TRICARE
- Veterans' benefits
- Long-term care insurance policies
- Indian Health Service, Tribal, and Urban Indian Health plans

MEDICARE PART D- Prescription Drug Coverage

Medicare prescription drug coverage is an optional benefit offered to everyone who has Medicare. If you decide not to get Medicare drug coverage when you're first eligible, you'll likely pay a **late enrollment penalty** if you join later, unless one of these applies:

- You have other creditable prescription drug coverage
- You get **Extra Help**
- Generally, you'll pay this penalty for as long as you have Medicare prescription drug coverage.

To get Medicare drug coverage, you must join a Medicare plan that offers prescription drug coverage. Each plan can vary in cost and drugs covered.

HOW DO I GET PRESCRIPTION DRUG COVERAGE?

01 **Medicare Prescription Drug Plan (Part D) .** These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.

02 **Medicare Advantage Plan (Part C) like an HMO or PPO)** or other Medicare health plan that offers Medicare prescription drug coverage. You get all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.” You must have Part A and Part B to join a Medicare Advantage Plan.

CONSIDER YOUR CHOICES CAREFULY-

Before you make a decision, **learn how prescription drug coverage works with your other drug coverage**. For example, you may have drug coverage from an employer or union, TRICARE, the Department of Veterans Affairs (VA), the Indian Health Service, or a Medicare Supplement Insurance (Medigap) policy. Compare your current coverage to Medicare drug coverage. The drug coverage you already have may change because of Medicare drug coverage, so consider all your coverage options.

If you have (or are eligible for) other types of drug coverage, read all the materials you get from your insurer or plan provider. Talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage.

HOW MUCH DOES A PART D PLAN COST?

While the monthly premium can range from $14.00 to $90.00 per month, some individuals may pay more because of higher incomes.

OK, BUT WHAT ABOUT THE ACTUAL COST OF THE MEDICATIONS?

Some plans have an annual **Deductible**. This is the amount you must pay each year for your prescriptions before your Medicare drug plan pays its share. Deductibles vary between Medicare drug plans. No Medicare drug plan may have a Deductible more than $480 in 2022. Some Medicare drug plans don't have a Deductible.

After you pay your plan's deductible (if your plan has one), the amount you pay for each prescription is either:

A copayment . With a copayment, you pay a set amount (like $10) for all drugs on a tier. You may pay a lower copayment for generic drugs than brand-name drugs.

Coinsurance . With coinsurance, you pay a percentage of the cost (like 25%) of the drug.

Some Medicare Prescription Drug Plans have levels or "tiers" of copayments/coinsurance, with different costs for different types of drugs.

SUMMARY

As you can see there are costs associated with Medicare, which by the way works quite well if you don't get sick. Regarding Medicare Health Plans there are no "One Size Fits All" plans available either so careful care must be taken when choosing one.

ABOUT ME

I am an independent agent that specializes in Senior Health Insurance planning. I will provide you with simple accurate information about all of your Medicare options. As an independent agent, I have access to all of the major carriers and the plans they offer in your area.

This ensures that you will get the most appropriate coverage at the lowest possible cost. I work for you **not** the Insurance Carriers and I'll handle everything from start to finish at **no cost to you** as I am compensated by the insurance carriers.

A, B, C's & D of Medicare Fact Sheet

A Hospital	B Medical	C	D Drugs
Monthly Prem ium: $0 (Must have paid In for 40 Quarters or Pay Monthly $278 up to $506) In Patient Hospital Stay Days 1 to 60: $1,600.00 deductible Days 61 to 90: $400 per day co-pay Days 91 to 150: $800 per day co-pay NO COST CAP $$$	Monthly (Income Based) From $164.90 up to $560.50 Deductible : $226.00 Co-Insurance : 20% PENALTY POSSIBLE! NO COST CAP $$$	MEDICARE ADVANTAGE PRESCRIPTION DRUGS	Required Purchased Through Private Insurance Premium Range $17 to $90 per month Plus MEDICATION CO-PAY PENALTY POSSIBLE!

Cost Control Solutions

Supplements / Medigap

- No Network: Any Doctor / Hospital that Accepts Medicare
- No Co-Pays or Very Low Co-Pays
- Covers Cost Share on A & B Only
- Must ADD Part D Drug Plan
- COSTS ARE CAPPED

M.A.P.D.

- Monthly Premium as Low as $ 0
- Co-Pays : Primary Care
Specialists
Hospitals
Tests
- Doctor / Hospital Networks Apply (HMO / PPO)
- COSTS ARE CAPPED

What is IRMAA?

The income-related monthly adjustment amount, or IRMAA, is a surcharge that highincome people may pay in addition to their Medicare Part B and Part D premiums. The Medicare IRMAA for Part B went into effect in 2007, while the IRMAA for Part D was implemented as part of the Affordable Care Act in 2011. IRMAA payments go directly to Medicare, even if you pay monthly premiums to an insurance company for Medicare Advantage or Part D prescription drug coverage.

The Social Security Administration (SSA) makes the determination about whether or not you're subject to IRMAA based on the income you reported in your tax return two years ago. For example, in 2020, the SSA looks at the 2018 income data you filed with your tax return.

Unlike late enrollment penalties, which can last as long as you have Medicare coverage, IRMAA is calculated every year. You may have to pay the adjustment one year, but not the next if your income falls below the threshold.

What are the income brackets for IRMAA Part D and Part B?

Single	Married Filing Jointly	Married Filing Separately	Part B Premium	Part D IRMAA
$97,000 or less	**$194,000** or less	**$97,000** or less	**$164.90**	**$0** + your plan premium
$97,001 to **$123,000**	**$194,000** to **$246,000**	N/A	**$230.80**	**$12.20** + your plan premium
$123,001 to **$153,000**	**$246,001** to **$306,000**	N/A	**$329.70**	**$31.50** + your plan premium
$153,001 to **$183,000**	**$306,000** to **$366,000**	N/A	**$428.60**	**$50.70** + your plan premium
$183,001 and under **$500,000**	**$366,001** and under **$750,000**	**$97,000** and under **$403,000**	**$527.50**	**$70.00** + your plan premium
$500,000 or above	**$750,000** and above	**$403,000** and above	**$560.50**	**$76.40** + your plan premium

PENALTIES

It is possible to incur a monthly Penalty with Medicare Parts A, B and D. Most people qualify for Free Part A and sign up when first eligible and don;t incur a penalty. Penalties mostly stem from inaction so special care should be taken to Parts B and D sign up dates, current coverage and premium payments.

HOW MUCH IS THE PART B LATE ENROLLMENT PENALTY?

- You'll pay an extra 10% for each year you could have signed up for Part B, but didn't.
- This penalty is added to your monthly Part B premium. (You may also pay a higher premium depending on your income.)
- It's not a one-time late fee - you'll pay the penalty for as long as you have Part B.
- Generally, you won't have to pay a penalty if you qualify for a Special Enrollment Period. To qualify, you (or your spouse) must still be working and you must have health coverage based on that job.

HOW MUCH IS THE PART D PENALTY?

- You'll pay an extra 1% for each month (that's 12% a year) you could have signed up for Part D, but didn't.
- The penalty is added to your monthly premium.
- It's not a one-time late fee - you'll pay the penalty each month for as long as you have Part D coverage (even if you change plans.)
- If you have credible drug coverage or if you qualify for Extra Help, you **won't** have to pay a penalty.

YOU MIGHT PAY A PENALTY IF YOU:

- Don't join a Medicare drug plan when you first get Medicare, **and**
- Go 63 days or more without creditable drug coverage (coverage that's similar in value to Part D).

Medicare Health Insurance Terms

NETWORK
A listing of Doctors,
Hospitals and Medical Services
accepted by an individual insurance carrier.

CO- PAYMENT
A SET DOLLAR AMOUNT THE INSURED HAS TO PAY NBRFORE THE INSURANCE COMPANY PAYS

CO-INSURANCE
A FIXED PERCENTAGE OF THE COST AN INSURED HAS TO PAY BEFORE THE INSURANCE COMPANY PAYS.

HMO
Stands for **Health Maintenance Organization. HMOs** have their own network of doctors, hospitals and other healthcare providers who have agreed to accept payment at a certain level for any services they provide. An insured must stay in Network or pay the full amount the Doctor bills Medicare for.

PPO
Is a **Preferred Provider Organization** that is a medical care arrangement in which medical professionals and facilities provide services to subscribed clients at reduced rates. PPO medical and healthcare providers are called "**Preferred Providers.**" An insured as the option of going in and out of Network and paying a reduced rate by staying in.

POS
A **Point-Of-Service** plan is a type of managed care plan that is a hybrid of HMO and PPO **plans.** Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for **health** care services.

FORMULARY
Under a healthcare plan, the list of covered prescription drugs is called a formulary.

DRUG TIERS
Are levels of coverage based on the type or usage of the medication. Each tier will have a defined out-of-pocket cost that the patient must pay before receiving the drug.

PREMIUM
The monthly amount paid to the insurance carrier for coverage.

ENROLLMENT PERIOD
As specific time period when an insured may change their insurance plan.

- **AEP**- Annual Enrollment Period- October 15 – December 7.
- **OEP**- Open Enrollment Period- January 1 – March 31.
- **SEP**- Special Enrollment Period- Anytime that certain conditions are met.