

A, B, C, Ds of Medicare



What you need to know for 2017

Introduction to Medicare



Medicare provides an excellent foundation for the health care coverage of retirees, but the program is unlikely to meet all of your medical needs. It is important that you understand how Medicare operates and what choices you have.

Original Medicare (Parts A and B) is administered by the Centers for Medicare and Medicaid Services (CMS). For Part C or Medicare Advantage plans, a private insurer provides all of the benefits of Original Medicare Parts A and B, receives a subsidy from CMS, and may provide

additional benefits. Medicare Part D, which covers prescription drugs, is administered by private insurance carriers that receive a subsidy from CMS.

The purpose of this booklet is to help you understand what the different parts of Medicare cover, and what they do not cover. The reality is that although Medicare is a comprehensive framework for health security in retirement, it doesn't cover everything, nor was it ever intended to do so. That's why access to supplemental insurance is so helpful because it helps you with healthcare costs that Medicare does not pay. You will also want to think about other out-of-pocket medical expenses beyond insurance coverage and factor them into your overall retirement budget. On average, Medicare is likely to pay only about 62% of your health care costs in retirement.¹ This booklet will help you to understand what your share of Medicare costs may be.

¹The Employee Benefit Research Institute (EBRI) estimates, *Issue Brief No. 317, May 2008, Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement: Findings from a Simulation Model*, by Paul Fronstin, EBRI, and Dallas Salisbury, EBRI, and Jack Van Derhaci, Temple University and EBRI Fellow.

Enrolling In Medicare

If you have been paying into Medicare through FICA payroll taxes during your working years and are age 65 and ready to retire, you are probably eligible for Medicare.

Here are Medicare's enrollment guidelines:

- If you are not applying for or not planning to receive your Social Security benefits for a while, you will need to enroll in Part A three months BEFORE turning age 65, EVEN IF YOU PLAN TO WORK BEYOND AGE 65.
- If you are applying for or already receiving Social Security benefits, you will be automatically enrolled in Part A and Part B at age 65.
- If you are receiving Social Security benefits and plan to keep working, you need to decline enrollment in Part B until you retire. You do not need to enroll in Part B until you actually retire.
- If you're under 65 and disabled, you'll automatically get Part A and Part B after you get disability benefits from Social Security.
- You may also be eligible if your spouse (or deceased spouse) has (had) Medicare, or if you are permanently disabled and have been receiving Social Security for 24 months.

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227) or visit the Medicare web site [medicare.gov](https://www.medicare.gov). The Medicare publication Medicare and You is a very thorough and readable reference for detailed information about Medicare.

Medicare and You and Your Medicare Benefits, both from the Centers for Medicare and Medicaid Services (CMS), are the sources for the information about Medicare in this booklet.



Health Care Reform

- The Medicare Coverage Gap Discount Program will continue to provide manufacturer discounts on brand name drugs to Part D beneficiaries who reach the Coverage Gap and are not already receiving “Extra Help.” A 50% discount on the negotiated price of preferred and non-preferred brand drugs (excluding the dispensing fee) will be available from manufacturers that have agreed to provide the discount at point-of-purchase.
- The Coverage Gap will continue to close between now and 2020. In 2017, if you are not already receiving “Extra Help,” your cost share in the Coverage Gap can be no more than 51% for covered Part D generic drugs and 40% for brand-name drugs. Some of the Emeriti plans offer enhanced coverage in the gap, which means your member cost share could be lower.

Will Medicare Cover Everything?

Medicare provides an excellent foundation for the healthcare coverage needs of retirees. However, it's important to note that there are many health expenses that Medicare doesn't cover completely, and others, such as vision, dental and hearing services, and long term care, where it provides no benefit. In fact, Medicare is estimated to cover only about 62% of your health care expenses in retirement, with the balance covered by private insurance and by your own out-of-pocket expenditures.¹

¹National Institute on Aging, Newsroom, *Dramatic changes in U.S. highlighted in new census, NIH report, June 26, 2013.*

An average couple, age 65, currently needs more than \$250,000 to cover healthcare costs in retirement.¹



¹EBRI Notes, October 2015. National average.

Medicare Part A - Hospital

Medicare Part A Coverage

Medicare Part A provides coverage for inpatient care in a hospital and skilled nursing facility, hospice care, home health care, and some other benefits. There is no monthly premium for enrollment in Medicare Part A if you have made sufficient FICA contributions during your working years. You should receive information from Medicare about Part A enrollment several months before your 65th birthday.



Part A has a **hospital deductible of \$1,288 in 2016**. The first 60 days of hospitalization, or the first 20 days in a skilled nursing facility, in a benefit period* are covered in full by Medicare; thereafter you must share in the cost or pay it in full. Some copays and coinsurance may also apply. The chart on the right shows the major types of coverages and benefit period or lifetime limits for Part A for 2016.

Please note, at the time of printing, 2017 Part A information was not available.

Medicare Part A - What is covered & what you pay

Coverage	You Pay
Hospitalization	Days 1-60:* \$0 coinsurance. Days 61-90:* \$322 coinsurance per day Days 91-150:* \$644 coinsurance per each lifetime reserve day after day 90 for each benefit period. Up to 60 days over your lifetime. After lifetime reserve days are exhausted, you pay 100%.
Skilled Nursing Facility	Days 1-20:* \$0 Days 21-100:* \$161.00 per day Beyond 100 days:* you pay 100%
Home Health Care	\$0 for medically-necessary care 20% of approved amount for durable medical equipment
Hospice Care	\$0 if you meet certain requirements. You pay \$5 coinsurance for prescription drugs for pain management. You pay a 5% co-payment for inpatient respite care.
Mental Health	Days 1-90 lifetime: Same cost sharing as inpatient hospitalization Days 91 and beyond: you pay \$644 per each lifetime reserve day
Blood	If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you, get in a calendar year or have the blood donated by you or someone else.

**A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60 day period for the same diagnosis, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.*

PLEASE NOTE: Medicare does not pay for custodial care or long-term care, whether at home or in a nursing home.

Medicare Part B - Medical

Medicare Part B Coverage

Part B services focus on physician visits, diagnostic testing, durable medical equipment, and some other services. Part B also covers many preventive services. There is a monthly premium for Medicare Part B that you pay. These premiums are based on your annual taxable income, on a phased-in basis. There will no Social Security cost of living increase for 2016. As a result, by law, most people with Medicare Part B will be “held harmless” from any increase in premiums in 2016 and will pay the same monthly premium as last year, which is \$104.90. **New beneficiaries not subject to the “hold harmless” provision will pay \$121.80 in 2016.** For existing beneficiaries, if your annual taxable income is \$85,000 (\$170,000 for joint filers) or less, your monthly premium is \$104.90 for 2016.

You should enroll when you are first eligible or you will pay a penalty of 10% for each full 12-month period that you were eligible but did not enroll. You do not pay this penalty if you do not sign up for Part B because you are covered under an employer’s active group plan or enrolled under a spouse/partner’s health plan, as long as you do sign up shortly after that coverage ends. (See Special Enrollment Period in Medicare and You at medicare.gov.)

Please note, at the time of printing, 2017 Part B information was not available.



Medicare Part B - what is covered & what you pay

There is a **calendar year annual deductible of \$166** in 2016 for Part B services, which means that you pay in full for the first \$166 of Medicare Part B expenses. Thereafter, your costs vary, depending on the service, as follows:

COVERAGE	YOU PAY
Physician charges	20%
Clinical laboratory services and diagnostic tests	0% for Medicare-approved services, 20% for covered diagnostic tests and x-rays
	Generally you pay nothing if you get your preventive care from a provider that accepts Medicare assignment, (mammograms; pap tests, pelvic exams; prostate cancer screenings; other screenings for those at high risk) <i>NOTE: Not all preventive services are covered every year. Check with Medicare for the coverage provisions for the appropriate service or screening.</i>
Durable medical equipment	20%
Outpatient therapy	20% (may be limits and exceptions)
Home health services	0% for Medicare-approved services
Outpatient hospital services	Coinsurance varies by service

Medicare Parts A & B - what is not covered

There are many health-related expenses that are not covered completely by Original Medicare (Parts A and B); and some others, such as vision, dental and hearing services, and long term care, where it provides no benefit.

Original Medicare (Parts A and B) does not cover:

- dental care and dentures
- routine vision and hearing care
- most eyeglasses and hearing aids
- routine foot care
- custodial or long term care
- some shots, tests and lab tests
- some diabetic supplies
- acupuncture and certain chiropractic services
- cosmetic surgery

And, of course, there are deductibles, coinsurance, and co-payments that you pay for the services that Medicare covers.

It is important to remember that Medicare provides no coverage for health care expenses while you are traveling outside the United States. (There are various exceptions to a number of these exclusions; contact Medicare for more specific provisions.)

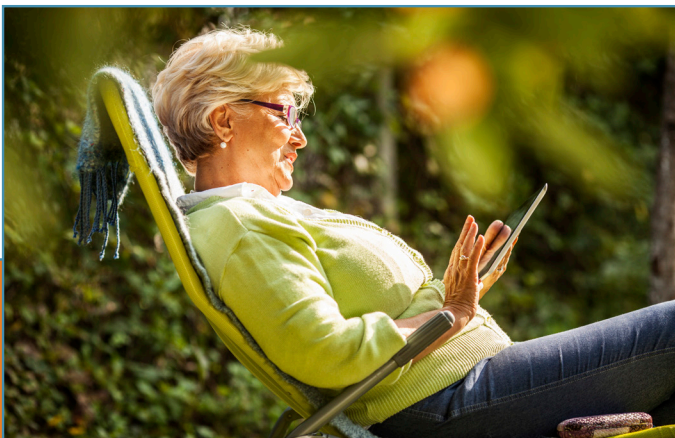
The Importance of Supplemental Insurance

Providers who do not accept Medicare assignment can balance bill you up to an additional 15% of the cost for covered services. This is called the Medicare Limiting Charge. Medicare does not pay any of this additional cost. Some supplemental plans may pay this cost.

If you're in a Medicare Advantage Plan or other Medicare plan, you may have different rules, but your plan must give you at least the same coverage as Original Medicare. Some services may only be covered in certain settings or for patients with certain conditions.

Medicare provides a solid foundation for your retiree health care, but there are also cost-sharing requirements on specific services, and there are no out-of-pocket limits for most Medicare-covered services.

It is for these reasons that Medicare suggests that you may want to purchase additional insurance that builds on the foundation of Original Medicare.



Medicare Part C - Medicare Advantage Plans

Medicare Advantage Plans

In Medicare Advantage, sometimes called “Part C” or “MA Plans,” your Medicare Parts A and B are assigned to a private insurer who provides you with comprehensive health care coverage. When enrolled in a Medicare Advantage plan, you must remain enrolled in Medicare Part A and Part B, and continue to pay your Part B premiums (and Part A premiums, if applicable). Medicare pays the insurer a fee to assume all of the benefit coverages defined by Original Medicare. The insurer becomes responsible for all of the Medicare-eligible health care costs and sometimes offers additional benefits, often extensive preventive services, beyond Original Medicare’s eligible services.

The CMS payments for Part C plans are dependent on Medicare’s reimbursement to providers, which vary significantly from one geographic area to another. Medicare Advantage plans may be structured in various ways, with co-payment or coinsurance (%) cost-sharing; all plans include an annual out-of-pocket maximum. The amount that Part C plans pay for Medicare-eligible expenses may be different from what Original Medicare would pay, but generally speaking the Medicare Advantage plan must pay at least what Medicare would have paid. In all cases you pay Part B premiums.

One type of Medicare Advantage plan is Preferred Provider Organization (PPO) Plans. The plan will provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all types of Medicare Advantage Plans, you’re always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care. Original Medicare covers hospice care even if you’re in a Medicare Advantage Plan. Medicare Advantage Plans are not supplemental coverage plans; a Medicare Advantage plan would become your primary insurance.



Medicare Cost Plans

A Medicare Cost Plan is another type of Medicare Part C plan that contracts as a Medicare Health Plan. Enrollees maintain their Medicare Part A and Part B benefits, enabling them to seek services by a non-contract provider. Cost plans do not have to offer a Medicare Part D option. If they decide to offer a Medicare Part D plan, the same Medicare rules apply to Cost plans.

Medicare Part D - Prescription Drugs

Part D Coverage

The Medicare Part D prescription drug benefit is designed to help Medicare-eligible retirees cope with the fastest rising component of their health care costs: prescription drugs. While the design of this benefit is rather complicated, here are the basics:

- you choose an insurer, and then you choose a plan of coverage
- you pay an annual premium for this insurance coverage
- you may also pay a separate premium directly to Medicare if you are in a higher income bracket
- you typically pay an initial deductible each year
- you pay your portion of the cost of covered Part D prescription drugs after the deductible according to the Part D plan's tier structure for the Initial Coverage and Coverage Gap stages, often with a different cost share by drug tier in each stage
- if you enter the catastrophic stage in a calendar year, the plan covers nearly all of the remaining costs of your prescription usage (typically the plan pays 95% or all but a small participant co-pay) for the rest of the calendar year

There are many variations on the Medicare Part D design. One of the most important prescription drug plan provisions is the type of formulary that the plan has. A formulary is a listing of covered drugs under the insurance plan. It outlines under what tier a drug would be covered to help you determine the cost share that you will be responsible for a specific drug. All Medicare Part D plans must comply with government requirements. CMS requires that the formulary provides access to an acceptable range of Part D drug choices, and that it includes drug categories and classes that cover all disease states.

Understanding Formularies

An **open formulary** means that all Part D drugs are available for coverage, although the plan may be designed with lower member cost sharing for generic and preferred brand drugs.

A **closed (or standard) formulary** is a subset of Medicare Part D drugs, and requires you to use only those medications that are designated as covered under the insurer's preferred drug list. If your brand drug is not covered on the closed formulary, you can speak to your doctor about switching to a drug that is on the preferred drug list; or your doctor may request a medical exception from the insurer for the drug to be covered. If you decide to continue taking medications not covered on the closed formulary without obtaining a medical exception, you will pay the full cost; and these expenses will not count toward the plan's deductible or out-of-pocket limits.

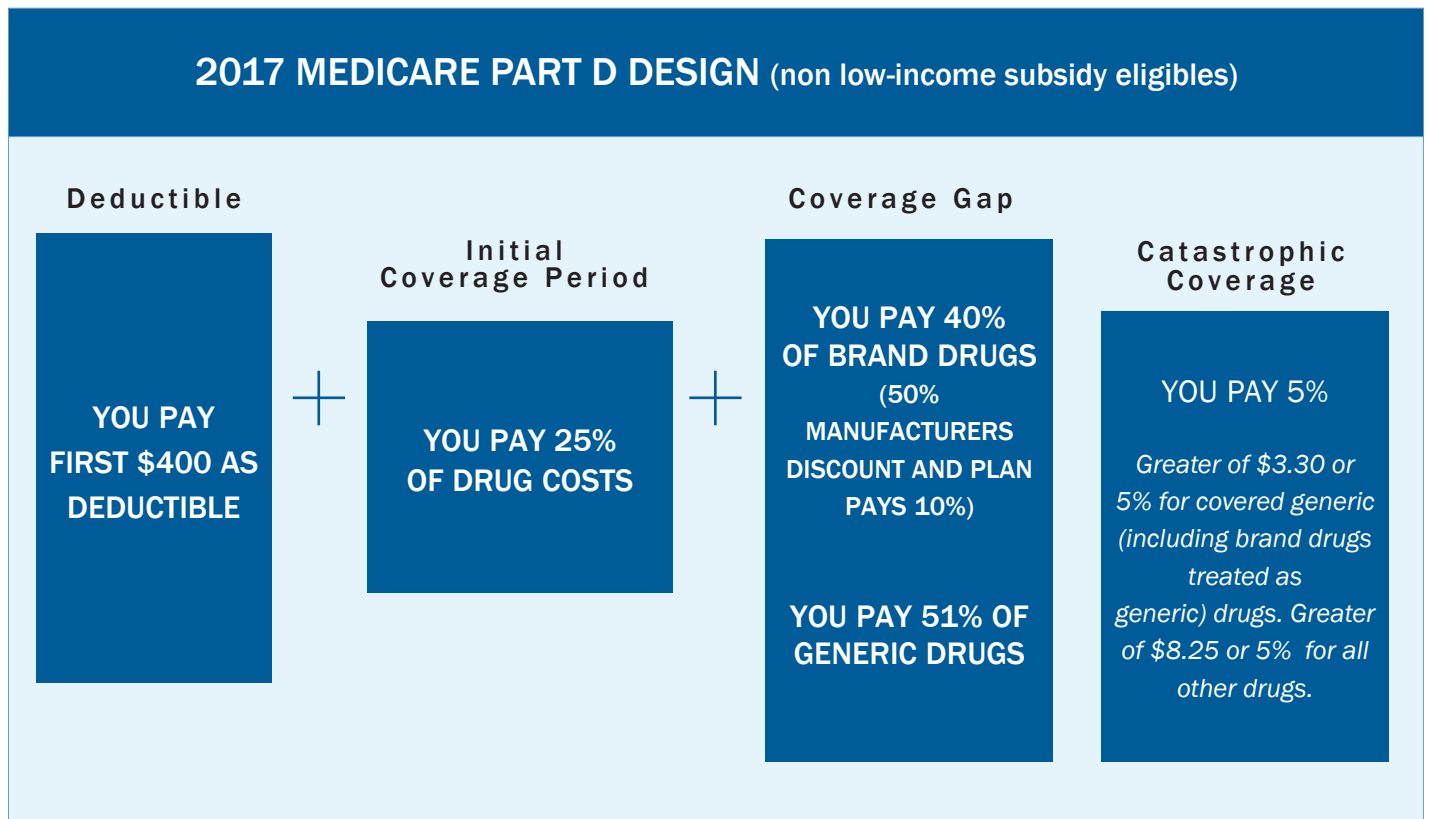
Enrolling in Part D Coverage

It is important to consider enrolling in a Part D plan when you are first eligible. A late enrollment penalty will be added to your Part D premium if you don't enroll during your initial enrollment period or if you don't have other creditable prescription drug coverage that pays, on average, at least as much as Medicare's standard prescription benefit. This would permanently increase your premiums by 1% of the "national base beneficiary premium" for each month you did not enroll or did not have creditable coverage. You do not pay the late enrollment penalty if you are eligible for the low income subsidy program. You can enroll in only one Part D plan at a time. Each year, during the Medicare open enrollment period in the fall, you can switch to a different provider or plan, with coverage becoming effective January 1st.

Medicare Part D - Prescription Drugs

How Part D Works

Emeriti's Part D plans are derived from the Medicare Part D benefit each year. In order to understand how Emeriti's plan provisions work, it's helpful to review Medicare's Part D design in the diagram below. Please note that all of Emeriti's plan options are richer than the benefit below, which represents the minimum amount of coverage that Medicare allows.



NOTE: You reach the Coverage Gap at \$3,700 in total Part D covered drug expenses. You reach Catastrophic Coverage at \$4,950 in true out-of-pocket costs.

The 2017 Medicare Standard plan design includes several phases of cost-sharing by you and the Plan. First, you pay a monthly premium. Then, as you begin to incur drug expenses, you pay the full cost, up to the annual Deductible amount. Then, you pay 25% coinsurance (the Plan pays 75%) for each prescription, up to the Initial Coverage Limit (total costs paid by you and the Plan). If you have additional costs in the calendar year, you enter the Coverage Gap, and you pay 40% of brand drug and 51% of generic drug costs and receive a 50% discount* on the cost of covered Part D brand drugs until your True Out-of-Pocket (called TrOOP) expenditures reach \$4,950. If your Rx expenditures exceed \$4,950, you move to Catastrophic Coverage, where you pay the greater of 5% or \$3.30 for covered Part D generic drugs (including brand drugs treated as generic drugs), and the greater of 5% or \$8.25 for all other covered Part D drugs.

In most plans you will be responsible for all costs for the following kinds of drugs:

- drugs not covered in a standard formulary plan, unless a medical exception is obtained
- nonprescription drugs
- drugs purchased outside of the U.S. and its territories
- prescription vitamins and mineral products
- drugs for treatment of sexual or erectile dysfunction
- weight control medications
- all other drugs that are not eligible for coverage under Medicare coverage guidelines

Please visit [medicare.gov](https://www.medicare.gov) for additional information.

**Refer to information on the Medicare Coverage Gap Discount Program on page 4.*

Healthcare Options in Retirement

Emeriti's Group Insurance Plans

Having reviewed how Medicare works, you no doubt appreciate why Medicare suggests that you consider purchasing additional insurance that builds on Original Medicare, to help pay for those expenses that Medicare does not pay in full.

One option is to enroll in post-65 group retiree medical insurance that coordinates with or supplements Medicare.

The Emeriti Retirement Health Plan, offered by your institution, provides a choice of national, post-65 group health plans that build on Original Medicare in different ways.

In 2017, depending on where you live, you may have a choice between two Aetna Supplemental Retiree Medical Plans K and L, and three Medicare Advantage PPO (PPO ESA) Plans.

For Minnesota-resident retirees from Minnesota institutions, HealthPartners provides two Cost plans, that contract as a Medicare health plan.

All Emeriti insurance choices include Medicare-approved Part D insurance at different levels of coverage and cost. Emeriti offers retiree health insurance nationwide, so no matter where you live in the U.S., you will be covered.

Emeriti insurance offerings provide catastrophic coverage, which limits your exposure to very high medical or drug costs in a calendar year.

Each year during Emeriti's open annual enrollment you will be able to switch to a different medical and drug plan based on your needs for the upcoming year. Even if you develop a very different medical situation, you can change plans for the next year, with no medical underwriting.

What To Look For In Individual Plans On The Open Market

Individual Medigap plans are tightly regulated by Medicare, and they coordinate with Medicare Parts A and B. There are a number of coverage options at varying costs, offered by insurance companies that choose to participate in various state and local markets.

New Medigap policies cannot offer prescription drug coverage; you will need to find a separate Part D plan if you want drug coverage.

One thing to keep in mind is that once you select an open market individual Medigap plan, it could become difficult to switch to a different plan as your needs change each year. Open market plans require medical underwriting in some states, and you may be deemed uninsurable or be required to pay a higher premium by the insurance provider. And if your insurer leaves your local market, you may become part of a closed group, with potentially much higher premiums.

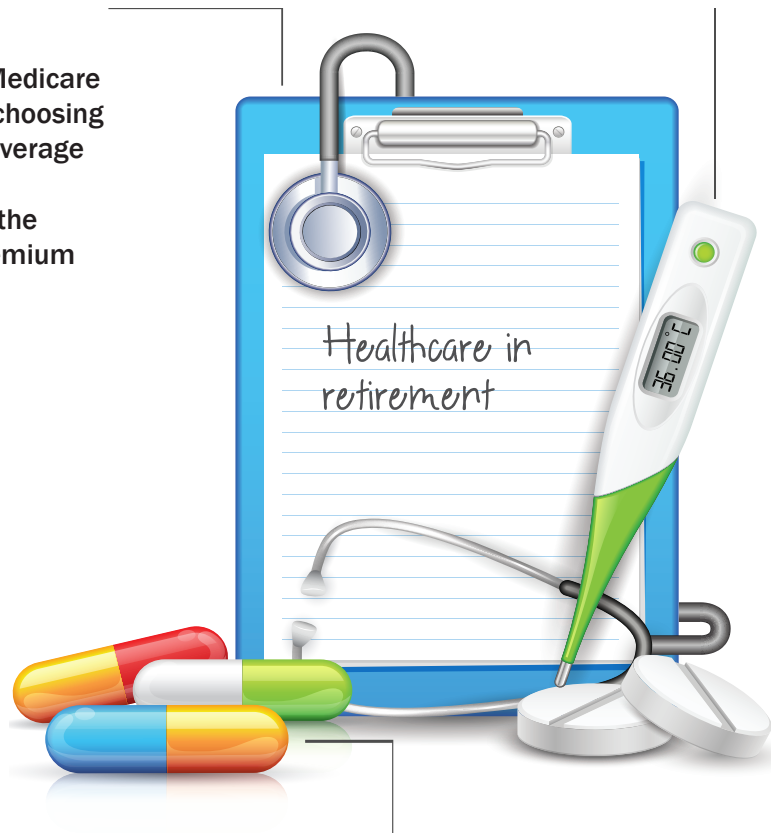
Please note that these restrictions do not apply to Emeriti insurance plans.

For more information about your Emeriti Retirement Health Plan, call 1-866-Emeriti (1-866-363-7484) or visit [Emeritihealth.org](https://www.emeritihealth.org).

1

ENROLL IN MEDICARE PARTS A & B

- You must enroll in Medicare Parts A & B before choosing additional health coverage
- You will always pay the Medicare Part B premium



2

CONSIDER ADDITIONAL MEDICAL COVERAGE

- Review available medical plans
- Choose between supplemental or Medicare Advantage plans

3

ADD A MEDICARE PART D PLAN

- Review available Rx plans
- Different plans cover different drugs with different cost-sharing arrangements