Mental Health Association of Northern Kentucky

A LEADER IN PROVIDING ADVOCACY, EDUCATION, AND SERVICES THAT PROMOTE MENTAL WELLNESS

EDUCATION AND SCREENING OUTREACH PARTNER FOR THE NATIONAL INSTITUTE OF MENTAL HEALTH AND NATIONAL MENTAL HEALTH ASSOCIATION

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Medicare

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it doesn't cover all medical expenses or the cost of most long-term care.

Medicare is financed by a portion of Federal Insurance Contributions Act (FICA) taxes, or payroll taxes, paid by workers and their employers. It also is financed in part by monthly premiums paid by beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) is the agency in charge of the Medicare program. But we—the people at the Social Security offices—help you enroll in the program and give you general Medicare information.

Medicare Has Two Parts

There are two parts of Medicare. They are:

- hospital insurance (also called Medicare "Part A"), which helps pay for care in a hospital and skilled nursing facility, home health care and hospice care; and
- medical insurance (also called Medicare "Part B"), which helps pay for doctors, out-patient hospital care and other medical services.

A Word About Medicaid

You may think that Medicaid and Medicare are two different names for the same program. Actually, they are two different programs. Medicaid is a state-run program designed primarily to help those with low income and little or no resources. The federal government helps pay for Medicaid, but each state has its own rules about who is eligible and what is covered under Medicaid. Some people qualify for both Medicare and Medicaid. For more information about the Medicaid program, contact your local medical assistance agency, social service or welfare office.

PART 2— WHO CAN GET MEDICARE? HOSPITAL INSURANCE (PART A) IF YOU ARE AGE 65 OR OLDER

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare hospital insurance (Part A) without paying a monthly premium based on their own—or their spouse's—employment. You are eligible at age 65 if:

- you receive or are eligible to receive Social Security benefits on your own work record or on someone else's work record as a spouse, divorced spouse, widow, widower, divorced widow, divorced widower, or parent; or
- you receive or are eligible to receive railroad retirement benefits; or

- you or your spouse (living or deceased, including divorced spouses) worked long enough in a government job where Medicare taxes were paid.

If you do not meet these requirements, you can still get Medicare hospital insurance by paying a monthly premium if you are a citizen or a lawfully admitted alien who has lived in the U.S. for at least five years.

If You Are Under Age 65

Before age 65, you are eligible for premium-free Medicare hospital insurance if:

- you have been entitled to Social Security disability benefits for 24 months. This includes widows, widowers and children who receive benefits because of disability; or
- you receive a disability annuity from the railroad retirement board and meet certain conditions; or
- you, your parent or your spouse (living or deceased, including a divorced spouse) have worked long enough in a government job where Medicare taxes were paid and you meet the requirements of the Social Security disability program.

If You Have Permanent Kidney Failure

If you have permanent kidney failure, you are eligible for free Medicare hospital insurance at any age. This is true if you receive maintenance dialysis or a kidney transplant and:

- you are eligible for or receive monthly benefits under Social Security or the railroad retirement system; or
- you have worked long enough in a Medicare-covered government job; or
- you are the child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked long enough under Social Security or in a government job where Medicare taxes were paid.

Extended Medicare Coverage for Working Disabled Beneficiaries

The Ticket to Work and Work Incentives Improvement Act of 1999 expands Medicare coverage for disability beneficiaries who work. Effective October 1, 2000, the new law extends Part A premium-free coverage for four and a half years beyond the current limit of 39 months for Social Security disability beneficiaries who work.

Medical Insurance (Part B)

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium.
If you are not eligible for free hospital insurance, you can buy medical insurance, without having to buy hospital insurance, if you are age 65 or older, and a citizen or lawfully admitted alien who has lived in the U.S. For at least five years. The medical insurance premiums are much less costly than the hospital insurance premiums.

Part 3—How Much Does Medicare Cost?

In addition to the monthly premiums you pay, there are other “out-of-pocket” costs for Medicare. These are the amounts you pay when you actually receive medical services, known as “deductibles” and “coinsurance.
For example, if you are hospitalized, you will be required to pay a deductible amount, and may have to pay coinsurance amounts, depending on how long you stay. If you receive medical services from a doctor, you pay a yearly deductible amount as well as a coinsurance amount for each visit.

The monthly premiums, deductibles and coinsurance for Medicare change each year. You can find out the current amount of these Medicare charges by contacting your local Social Security office or calling Social Security's toll-free number.

Part 4—Help For Some Low- Income Medicare Beneficiaries

If you cannot afford to pay your Medicare premiums and other costs, you may be able to get help from your state. You may qualify for a Medicare assistance program as a "Qualified Medicare Beneficiary" (QMB), "Specified Low-Income Medicare Beneficiary" (SLMB) or "Qualifying Individual (QI)."
These programs are for certain people who are entitled to Medicare and have low income. They may pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance. To qualify, you must have Part A (hospital insurance), a limited income, and your assets, such as bank accounts, stocks and bonds, must not be more than $4,000 for a single person or $6,000 for a couple.
If you are not sure if you have Part A, look on your red, white and blue Medicare card. It will show "Part A (hospital insurance)" on the lower left corner of the card, or call Social Security toll-free.

Part 5—Signing Up For Medicare When Should I Sign Up For Medicare?

If you're already getting Social Security retirement or disability benefits or railroad retirement checks, you will be contacted a few months before you become eligible for Medicare and given the information you need. 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.
If you aren't already getting retirement benefits, you should contact us about three months before your 65th birthday to sign up for Medicare. You can sign up for Medicare even if you don't plan to retire at age 65.
You also should contact Social Security about applying for Medicare if:

- you're a disabled widow or widower between age 50 and age 65 but haven't applied for disability benefits because you're already getting another kind of Social Security benefit;
- you're a government employee and became disabled before age 65;
- you, your spouse or your dependent child has permanent kidney failure;
- you had Medicare medical insurance in the past but dropped the coverage; or
- you turned down Medicare medical insurance when you became entitled to hospital insurance.

Initial Enrollment Period

When you first become eligible for hospital insurance (Part A), you have a seven-month period to sign up for medical insurance (Part B). This is called your "initial enrollment period." If you are eligible at age 65, your initial enrollment period begins three months before your 65th birthday, which includes the month you turn age 65 and ends three months after that birthday. If you are eligible for Medicare based on disability or permanent kidney failure, your initial enrollment period depends on the date your disability or treatment began.

If you already receive retirement or disability benefits, you will be automatically enrolled in Part B when you become entitled to Part A. However, because you must pay a premium for Part B coverage, you have the option of paying for the coverage or turning it down.

When Does My Enrollment In Part B Become Effective?

If you accept the automatic enrollment in Medicare Part B, or if you enroll in Medicare Part B during the first three months of your initial enrollment period, your medical insurance protection will start with the month you are first eligible. If you enroll during the last four months, your protection will start from one to three months after you enroll.

The following chart shows when your Medicare Part B becomes effective:

If you enroll in this month of your Initial Enrollment Period:	Then your Part B Medicare coverage starts:
1	the month you become eligible for Medicare
2	the month you become eligible for Medicare
3	the month you become eligible for Medicare
4	one month after enrollment
5	two months after enrollment
6	three months after enrollment
7	three months after enrollment

General Enrollment Period

If you don't enroll in Medicare Part B during your initial enrollment period, you have another chance each year to sign up during a "general enrollment period" from January 1 through March 31. Your coverage begins the following July. However, your monthly premium increases 10 percent for each 12-month period you were eligible but didn't enroll.

A Word About Your Medicare Card

Once you are enrolled in Medicare, you will receive a red, white and blue Medicare card showing whether you have Part A, Part B or both. Keep your card in a safe place so you'll have it when you need it. If your card is ever lost or stolen, you can apply for a replacement card on the Internet at www.socialsecurity.gov or call our toll-free number.

What If I'm Still Covered Under An Employer Group Health Plan?

If you are 65 or older and are covered under a group health plan either from your own or your spouse's current employment, you have a "Special Enrollment Period" in which to sign up for Medicare Part B. This means that you may delay enrolling in Medicare Part B without having to wait for a general enrollment period or pay the 10 percent premium surcharge for late enrollment. The rules allow you to:

- enroll in Medicare Part B any time while you are covered under the group health plan; or
- enroll in Medicare Part B during the eight-month period that begins with the month your group health coverage ends, or the month employment ends—whichever comes first.

If you enroll in Part B while covered by an employer-provided group health plan or during the first full month when not covered by that plan, you have the option to have your coverage begin the first day of the month you enroll or to delay coverage until the first day of any of the following three months.
If you enroll during any of the seven remaining months of the special enrollment period, your coverage will begin the month after you enroll.
Special enrollment period rules do not apply if employment or employer-provided group health plan coverage ends during your initial enrollment period.
If you do not enroll by the end of the eight-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

People who receive Social Security disability benefits and are covered under a group health plan from either their own or a family member's current employment also have special enrollment period and premium rights that are similar to those for workers age 65 or older.

Special Enrollment Period And Medigap

When you make your decision as to when to enroll in Part B, you must consider how this will affect your eligibility for other health insurance policies you may wish to purchase to supplement your Medicare coverage. Such supplemental policies are known as "Medigap" insurance.

When you enroll in Medicare Part B at or after age 65, you trigger a one-time "Medigap open enrollment period." If you enroll in Part B while you are covered under an employer-provided group health plan, you may not need a Medigap policy. Your employer will be the primary payer, and your Medicare Part B will be the secondary payer. Later, however, when you are no longer covered by your employer-provided group health plan, you may need a Medigap policy, but may be unable to purchase one because your Medigap open enrollment period will have expired.

If, on the other hand, you delay Part B enrollment until your employer-provided group health plan coverage is about to stop, you will be able to use your open enrollment period to your best advantage. During open enrollment, you may purchase any Medigap plan from any company at its most favorable price for your age group. You can purchase policies that cover outpatient prescription drugs, which generally are not available outside of the open enrollment period unless you are healthy.

Part—6 What Medicare Covers

The two parts of Medicare are designed to help pay for different kinds of health care costs. Some kinds of health care aren't covered by Medicare at all.

Hospital Insurance (Part A)

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care and hospice care. Except for home health care, each is subject to a "benefit period," which measures your use of services covered by Medicare Part A.
A benefit period starts the day you enter a hospital. It ends when you have been out of the hospital or other facility primarily providing skilled care for 60 days in a row. If you remain in such a facility (other than a hospital), a benefit period ends when you have not received any skilled care there for 60 days in a row. There is no limit to the number of benefit periods for hospital and skilled nursing facility care. But special limits do apply to hospice care.

Inpatient Hospital Care

If you need inpatient care, hospital insurance helps pay for up to 90 days in any Medicare-participating hospital during each benefit period. Hospital insurance pays for all covered services for the first 60 days, except for a deductible amount that you must pay. For days 61 through 90, hospital insurance pays for all "covered services" except for a daily coinsurance amount that you must pay.
If you are out of the hospital for at least 60 days in a row, and then go back in, a new benefit period begins—your 90 days of coverage starts all over again and you pay another deductible.
What if you need more than 90 days of inpatient care during any benefit period? You can use some or all of your "reserve days." Reserve days are an extra 60 hospital days you can use if your illness keeps you in the hospital for more than 90 days. You have only 60 reserve days in your lifetime, and you decide when you want to use them. For each reserve day you use, hospital insurance pays for all covered services, except for a daily coinsurance amount.

Skilled Nursing Facility Care

If you need inpatient skilled nursing or rehabilitation services after a hospital stay and you meet certain other conditions, hospital insurance helps pay for up to 100 days in a Medicare-participating skilled nursing facility in each benefit period.
Hospital insurance pays for all covered services for the first 20 days. For the next 80 days, it pays for all covered services, except for a daily coinsurance amount.

Note:

> It is important to know that Medicare does not pay for "custodial care" when that is the only kind of care that you need. Custodial care is the type of care many people receive in nursing homes. It is care that could be given by someone who is not medically skilled (for example, help with dressing, walking or eating).

Home Health Care

If your health problems cause you to stay at home and meet certain other conditions, Medicare can pay the full approved cost of home health visits from a Medicare participating home health agency. There is no limit to the number of covered visits you can have.
If you need one or more of the services Medicare pays for, then hospital insurance also covers part-time or intermittent services of home health aides, occupational therapy, physical therapy, medical social services and medical supplies and equipment. A 20 percent co-payment applies to covered durable medical equipment (e.g., wheelchairs and hospital beds).

Hospice Care

A hospice program provides pain relief and other support services for terminally ill people. Medicare hospital insurance can help pay for hospice care for terminally ill beneficiaries if the care is provided by a Medicare-certified hospice and certain other conditions are met.
You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than six months to live. Even if you live longer than six months, you can get hospice care as long as your doctor recertifies that you are terminally ill.
Hospice care is given in periods of care. As a hospice patient, you can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period of care, your doctor must certify that you are terminally ill in order for you to continue getting hospice care. A period of care starts the day you begin to get hospice care. It ends when your 90- or 60-day period is up. If your doctor recertifies that you are terminally ill, your care continues through another period of care.

Medical Insurance (Part B)

Medicare medical insurance helps pay for doctors' services and many other medical services and supplies that are not covered by the hospital insurance part of Medicare. Each year, you must pay an annual medical insurance deductible amount before Medicare begins paying. After you have paid the deductible, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year. You are responsible for paying the remaining 20 percent of the cost. This is called coinsurance.
Medical Insurance (Part B) covers:

- inpatient medical care;
- outpatient hospital care;
- inpatient and outpatient medical supplies;
- ambulance services;

- X-rays;
- laboratory tests;
- durable medical equipment such as wheelchairs and home orthopedic beds;
- services of certain especially qualified professionals that are not doctors;
- physical and occupational therapy;
- speech therapy;
- partial hospitalization for psychiatric medical attention;
- home attention if you don't have part A;
- blood;
- yearly mammograms;
- Pap smears;
- pelvic and breast examinations;
- diabetes glucose monitoring and education;
- colorectal cancer screenings;
- bone mass measurements;
- flu and pneumococcal pneumonia shots

Part—7 What Medicare Does Not Cover

Medicare provides basic health care coverage, but it doesn't pay all of your medical expenses. Here are examples of what Medicare does not pay for:

- custodial care;

This is care that could be given safely and reasonably by a person who is not medically skilled and that is given mainly to help the patient with daily living. Examples include help with walking, bathing and dressing. Even if you are in a participating hospital or skilled nursing facility, or you are getting care from a participating home health agency, Medicare does not cover the cost of care if it is mainly custodial.

- most nursing home care;
- dental care and dentures;
- routine checkups and the tests directly related to these checkups (some screening, Pap smears and mammograms are covered);
- most immunization shots (some flu and pneumonia shots are covered);
- most prescription drugs;
- routine foot care;
- tests for, and the cost of, eyeglasses or hearing aids;
- personal comfort items, such as a phone or TV in your hospital room; and
- services outside the United States.

Part 8—Options for Receiving Health Services

Medicare beneficiaries may have choices for receiving health care services. What you choose is a personal decision based on your particular health needs. However, you should consider all of the options carefully and decide what is best for you. A well-informed and well-thought-out decision could save you a lot of money and inconvenience.

Original Medicare Plan

Under the Original Medicare Plan, you can visit the hospital, doctor, or health care provider of your choice who accepts Medicare patients. Medicare pays a set percentage of the expenses, and you are responsible for certain deductibles and coinsurance payments, the portion of the bill Medicare does not pay.

Medigap Insurance

Medicare provides basic health care coverage, but it can't pay all of your medical expenses. For this reason, many private insurance companies sell insurance to fill in the gaps in Medicare coverage. This kind of insurance is called "Medigap" for short. There are 10 standard Medigap policies, and each offers a different combination of benefits.

Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide for Medicare deductibles. Some of the 10 standard policies pay for services not covered by Medicare, such as outpatient prescription drugs and preventive screening.

You may want to consider a Medicare SELECT policy, which is a Medigap policy in which you are required to use certain hospitals and doctors. The SELECT policies generally have lower premiums than other Medigap policies.

When you first enroll in Medicare Part B at age 65 or older, you have a six-month "Medigap open enrollment period." During that time, you have a right to buy the Medigap policy of your choice regardless of any health problems you may have. The company cannot refuse you a policy or charge you more than other open enrollment applicants.

Medicare Managed Care Plans

Another available option, which may save you money and provide additional benefits, is joining a managed care plan. The most common ones are health maintenance organizations (HMO's).

Medicare Managed Care Plans that have contracts with the Medicare program must provide all hospital and medical benefits covered by Medicare. However, usually you must obtain services from your Managed Care Plan's network of health care providers (doctors, hospitals, skilled nursing facilities, for example). In most cases neither the Managed Care Plan nor Medicare will pay for services not authorized by your Managed Care Plan (except emergency services or services urgently required while you are out of the Managed Care Plan's service area).

Each Managed Care Plan that has a contract with Medicare gets paid every month for service it provides to you. As a Medicare Managed Care Plan member, you will have to enroll in Medicare Part B and you will also have to continue to pay your Part B monthly premium.

Many Managed Care Plans that have contracts with Medicare also provide benefits beyond those Medicare pays for. These include preventive care, prescription drugs, dental care, hearing aids and eyeglasses. The benefits may vary by Managed Care Plan and you'll need to read the individual descriptions to determine which benefits are offered by each.

Private Fee-For-Service Plan

This is a new health care choice in some areas of the country. A Private Fee-for-Service plan is a Medicare health plan offered by a private insurance company. It is not the same as the Original Medicare Plan, which is offered by the federal government. In a Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private company. The private company provides health care coverage to people with

Medicare on a pay-per-visit arrangement. The insurance company, rather than the Medicare program, decides how much you pay for the services you get.

Part 9—If You Have Other Health Insurance

Medicare hospital insurance is premium free for almost everyone, but you do pay a monthly premium for medical insurance. If you already have other health insurance when you become eligible for Medicare, is it worth the monthly premium cost to sign up for Medicare medical insurance?

The answer varies with the individual and the kind of other health insurance. Although we can't give you "yes" or "no" answers, we can offer a few tips that may be helpful when you make your decision.

If You Have A Private Insurance Plan

Get in touch with your insurance agent to see how your private plan fits with Medicare medical insurance. This is especially important if you have family members who are covered under the same policy. And remember, just as Medicare doesn't cover all health services, most private plans don't either. In planning your health insurance coverage, keep in mind that most nursing home care is not covered by Medicare or private health insurance policies. One important word of caution: for your own protection, don't cancel any health insurance you now have until your Medicare coverage actually begins.

If You Have Health Insurance From An Employer-Provided Group Health Plan

Group health plans of employers with 20 or more employees are required by law to offer workers who are age 65 (or older) the same health benefits that are provided to younger employees. They must also offer the spouses who are age 65 (or older)—of workers of any age—the same health benefits given younger spouses.
If you are age 65 or older and are currently employed—or you are age 65 or older and are the spouse of a person who is currently employed—and you accept the employer's health insurance plan, Medicare will be the secondary payer. This means the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.
If you reject the employer's health plan, Medicare will be the primary health insurance payer. The employer is not allowed to offer you Medicare supplemental coverage if you reject his or her health plan.
If you are under 65 and disabled, and you are currently employed or are the family member of a person who has current employment and you have health coverage under a "large group health plan," Medicare will be the secondary payer. A large group health plan covers employees of an employer or group of employers of which at least one employer has 100 or more workers.
If you are entitled to Medicare because of permanent kidney failure and you have employer-provided group health coverage, Medicare will be the secondary payer for the first 30 months of your Medicare Part A eligibility or entitlement. At the end of the 30-month period, Medicare becomes your primary payer.

If You Have Health Care Protection From Other Plans

If you have coverage under a program from the Department of Defense, your health benefits may change or end when you become eligible for Medicare. You should contact the Department of Defense or a military health benefits advisor for information before you decide whether or not to enroll in Medicare medical insurance.
If you have health care protection from the Indian Health Service, Department of Veterans Affairs or a state medical assistance program, contact the people in those offices to help you decide whether it is to your advantage to have Medicare medical insurance.