Understanding Medicare

and YOUR options

Provided as a service by

UPMC *for Life*

UPMC Health Plan Medicare Program

Current or Soon-to-Be Medicare Beneficiaries

This booklet was written to help you understand Medicare and the health care options available to you.

Note:
It provides an overview of the four parts of Medicare — A, B, C, and D and a description of your choices. It was written by UPMC *for Life* to help you understand what Medicare is and the choices you have for coverage. Resources for more complete and detailed information can also be found in the Resources section, page 35.

Preface

A Little History of Medicare

In 1965, Congress passed legislation creating Medicare, the federal government insurance program for citizens 65 and older. The goal was to make affordable, comprehensive medical insurance available to all senior citizens. In 1966, its first year of operation, 19 million people were enrolled. In 1972, Medicare was expanded to include people of any age with permanent disabilities and people with end-stage renal disease.

Original Medicare stayed basically the same for 10 years, until Medicare beneficiaries were given the option to replace their Medicare Parts A and B coverage with coverage under Medicare Risk plans. Medicare Risk plans were provided through private insurance companies and funded by the federal Medicare program. In 1997, the Medicare Risk name was changed to Medicare + Choice.

Medicare + Choice plans were provided through private insurance companies and funded by the Federal Medicare program and beneficiary programs.

The next major change occurred in 2003, when the Medicare Modernization Act was passed. This created the Part D Prescription Drug program for outpatient prescription drugs, which was implemented in 2006 and changed Medicare + Choice to Medicare Advantage. These Part D plans are entirely operated by private companies who get subsidies from Medicare.

Note:
Many of the Medicare Advantage plans also developed Medicare Advantage Prescription Drug programs at this time, so beneficiaries could get medical and prescription drugs with one insurance company.

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Introducing You to Medicare

The First Thing You Should Know About Medicare:

It does not cover all medical costs.

Medicare is the federal government program that offers medical insurance coverage to people 65 and over (and to the disabled of any age). It was passed by Congress in 1965 to help citizens 65 and older with their health care costs. Prior to this time, retirees 65 and older who did not have retiree coverage through an employer had to either pay their own medical costs, or buy an individual medical plan.

The Original Medicare program does require you to pay some of your medical costs. The amount you pay, or your "medical cost-sharing," can be substantial, especially if you already have or develop serious medical conditions. This can be a big surprise to Medicare beneficiaries when they first enroll in Medicare.

What are the choices or alternatives to Original Medicare? Two of the most popular are Medicare Advantage plans and Medicare Supplement plans. While Medicare governs the types of private insurance coverage that can be offered, the cost of the insurance is up to the insurance plan and driven in part by the marketplace and industry competition. So it pays to shop around and compare prices and benefits.

Before explaining the coverage options that are available in addition to Original Medicare, we would like to provide you with an overview of the four parts of the Medicare program.

Part A and Part B are known as "Original Medicare."

- Coverage in Part A includes hospital, skilled nursing facility, home health care, and hospice costs. The insurance is free (if you paid enough in Medicare taxes).
- Coverage in Part B includes medical and doctor costs and there is a monthly premium ($96.40 for 2009). This premium may be higher depending on your income, and it may also change each year.

Parts C and D are not Medicare, but are private insurance plans that are regulated by the federal government through the Centers for Medicare & Medicaid Services (CMS).

- Part C is the "Medicare Advantage Plan," which replaces Part A and Part B coverage with a managed care insurance plan (like an HMO or a PPO).
- Part D is the name used for private prescription drug plan.

There is also a type of private insurance that is known simply as Medicare Supplement Insurance ("Supp plans" or "Medigap" plans). A Medicare Supplement Insurance plan picks up some medical costs not covered by Original Medicare. Medicare Supplement plans have been around a long time, almost since the beginning of Original Medicare.

Now that you have some background on the basic structure of Medicare, let's take a look at some of the "gaps" in coverage with Original Medicare. There are three different types of gaps.

Gaps in Original Medicare Coverage

1. The first gap you can face is the **deductible**. This is the amount you must first pay out of any charges before insurance coverage kicks in. For example, in Part B of Original Medicare, beneficiaries must pay a $135 annual deductible in 2009 before being reimbursed for provider fees. And this deductible amount may increase on an annual basis. Also in 2009 there is a hospital inpatient deductible of $1,068 per benefit period.

2. The second type of gap is a **coinsurance**. This is a percentage of the Medicare approved amount, say 20%, which the insurance does not cover. For example, you may have to pay 20% of the surgeon's fee for an operation under Part B.

3. **Copays** are fees that you pay on a per-service basis, such as a per doctor office visit fee of $20 or a per prescription drug charge of $10. Or you may have to pay a copay of $256 per day for days 60-90 of a hospital stay under Part A.

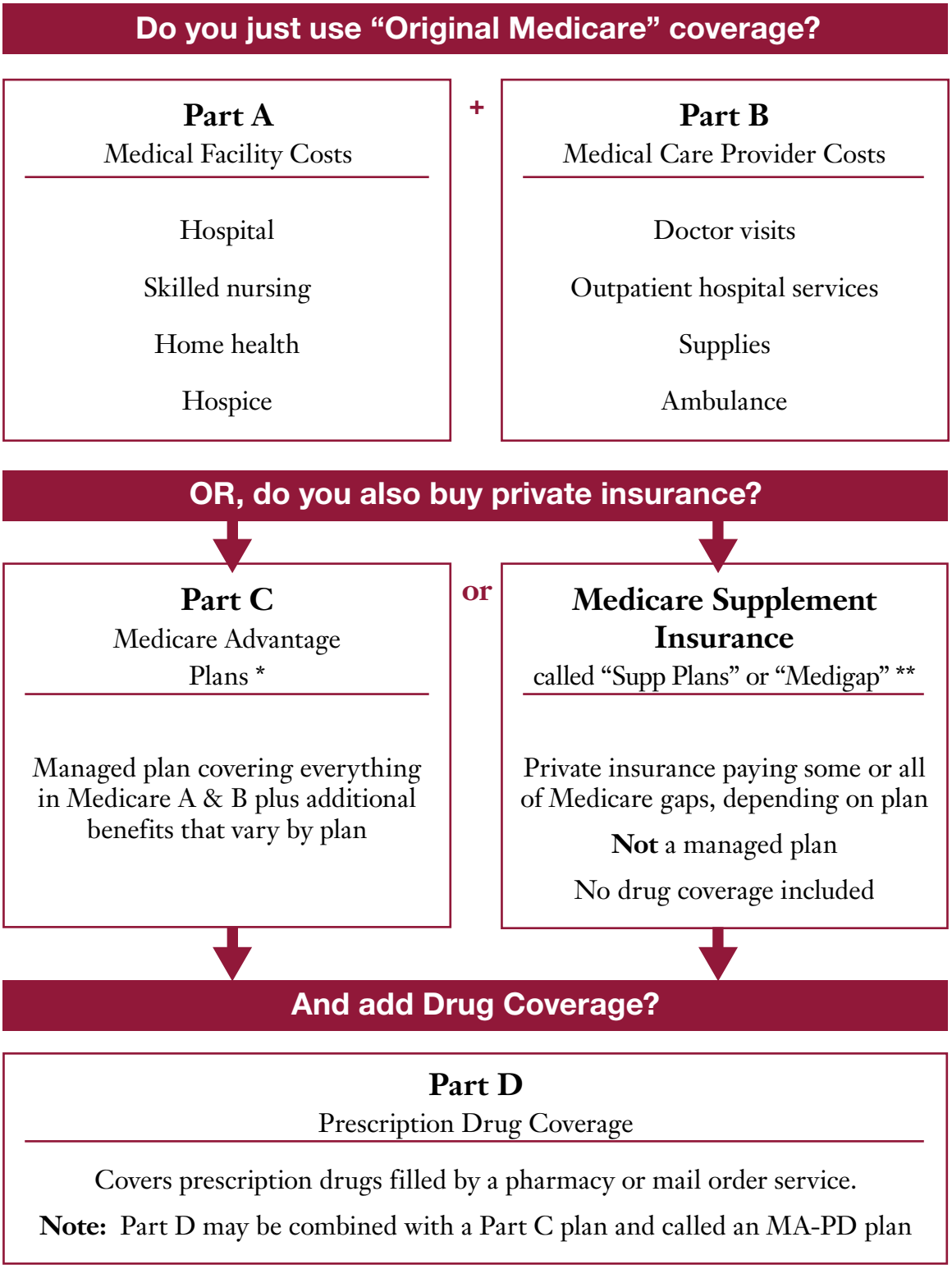
Comparing the copays, deductibles, and coinsurance of Medicare Advantage plans should be part of your decision if you choose to replace Original Medicare with a Medicare Advantage plan.

Out-of-Pocket Maximum

Note:
The out-of-pocket copays, deductibles, and coinsurances that you may pay as part of your plan cost-sharing can add up quickly, depending on the services you receive during the year. Some Medicare Advantage plans offer a limit on the amount of money you pay annually in deductibles, coinsurance, and copays. When that maximum amount is reached, the insurance pays 100% of the costs for the rest of the year for the plan's covered charges. For this reason, an out-of-pocket maximum can be a desirable feature in a private insurance plan.

To Sum It Up:

Medicare does not cover all of your potential medical expenses. In the following pages, you'll see ways you can cover these gaps with additional private insurance. When examining your coverage options, it's important to consider whether the plan has an out-of-pocket maximum, what the dollar amount of each copay is on each type of service, and whether there is a maximum on the number or total amount of copays for a specific covered benefit.



* These plans replace your Original Medicare Plan.

** You buy this plan in addition to having Original Medicare.

Some Details on Original Medicare Part A and B

Part A — Medical Facility Costs

Medicare Part A insurance will pay for:

- Hospital inpatient treatment costs, including a portion of the costs of:
  - Semiprivate room
  - Meals
  - General nursing
  - Blood (after first 3 pints)
  - Other hospital services and supplies
- Skilled nursing facility costs ("Skilled care" is medically necessary care requiring skilled nursing or rehabilitation staff.)
- Hospice
- Home health care

Custodial care, or what may be referred to as long-term care, is not covered by Part A.

Hospital Coverage

First 90 Days

Hospital stays are covered for the first 60 days, but you must pay a deductible of $1,068 with Original Medicare. After the first 60 days, you pay a daily copay of $267 per day for days 61-90. Both of these copays are for a benefit period.

Benefit Period

What is a benefit period? A benefit period is established when you enter a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after the benefit period has ended, a new benefit period begins.

Lifetime Reserve Days
What if you need more than 90 days of hospitalization in one benefit period? You are responsible for 100% of the costs of those days in excess of 90 days. But there is an exception. Everyone on Original Medicare gets what are called "Lifetime Reserve Days." This "reserve" is 60 days of hospital stay coverage available to you over your lifetime. When you are using lifetime reserve days, you are responsible for paying a copay of $534 per day.

Skilled Nursing Facility Coverage

Skilled nursing facility stays are limited to 100 days per benefit period. A benefit period starts the day you go into a hospital or skilled nursing facility and ends when you haven't received any inpatient hospital care or skilled care in a skilled nursing facility for at least 60 days in a row.

If you move between a skilled nursing facility and a hospital stay without a 60-day separation, the nursing home days are cumulative in counting toward the 100 day limit. As an example: If you leave the hospital after 20 days and go into a skilled nursing facility for 30 days, this is considered one benefit period and a total of 50 days are counted towards the 100 day limit. If after the 30 day skilled nursing facility stay you return to the hospital for 60 days, you now have a 110 day stay so the last 10 days are 100% your responsibility.

What Does Medicare Part A Cost?

Medicare Part A Premium:
You are covered by Medicare Part A without having to pay a premium if you (or your spouse) worked for 10 years and paid Medicare taxes. If you didn't, there is a sliding scale premium that can be as high as $443 per month (in 2009). This amount may increase annually.

Part A Deductibles and Copayments (for 2009)

Inpatient Hospital

Deductible	Days 61 - 90	Days 91 - 150 (once per lifetime)
$1,068	$267 per day	$534 per day

All per benefit period.

Skilled Nursing

Days 1 - 20	Days 21 - 100	Days per Benefit Period
$0	$133.50 per day	100

All per benefit period.

Note:
There are additional costs that are your responsibility, such as the first three pints of blood. Please see www.Medicare.gov for a detailed listing of Medicare covered charges and expenses. Custodial care, or what you may know as long-term care, is not covered under Medicare Part A.

Please note that these copays, deductibles, and coinsurance are subject to change each calendar year.

Medicare Part B Costs

Medicare Part B insurance will pay for a portion of medically necessary doctor fees and other medical services not covered under Medicare Part A.

The cost of a surgeon's services is covered under Medicare Part B coverage (with some minor exceptions), whether on an inpatient or outpatient basis. It also provides coverage for other outpatient services such as:

- Lab and x-ray services
- Ambulance services
- Preventive services (like exams and immunizations)
- Equipment like prosthetics, wheelchairs, and hospital beds

Medicare Part B deductibles and coinsurance are a little simpler than those in Medicare Part A. In 2009, you pay the first $135 per year for doctor and medical services (the deductible), and then you pay a 20% coinsurance of the Medicare allowed fee for the covered service.

> **Note:**
> There may be additional costs if the provider does not accept the Medicare allowed fee.

For example, if you saw your doctor in the office and the fee was $50, and the doctor performed outpatient surgery on you for a Medicare allowed fee of $3,000, you would pay:

- The $50 office visit, plus
- Another $85 to meet the deductible of $135, plus
- 20% of the remainder of $2,915 ($3,000 - $85 = $2,915) 20% of $2,915 equals $583.

Your total cost would be $135 plus $583 or $718.

If the doctor does not accept the Medicare allowable fee schedule, your costs may be higher than the 20% coinsurance.

> **Note:**
> Medicare deductibles are set by Congress on a yearly basis and typically increase annually.

Part B Premiums
In 2009, Part B has a monthly premium of $96.40 (or higher if you earn more than $85,000 as a single person or $170,000 as a married couple). Medicare Part B premiums also typically increase each year.

Part B Deductibles / Coinsurances (for 2009)

Annual Deductible	Coinsurance for covered physicians and outpatient medical services	Coinsurance for covered outpatient mental health services
$135	20%	50%

Covering the Gaps

Two Main Ways to Cover Part A and B Gaps

You have two options to cover the "gaps" in your care under Medicare.

Option One
The first is to enroll in a Medicare Supplement plan, which fills in some or all of the deductible, coinsurance, and copay gaps in Original Medicare.

> **Note:**
> Medicare Supplement plans do not replace Original Medicare; they "supplement" Original Medicare.

Also, Supplement plans do not come with a built-in prescription drug plan. You must buy an additional prescription drug plan if you want prescription drug coverage with your Medicare Supplement plan.

Option Two
The second option is to enroll in a Medicare Advantage plan, which replaces Original Medicare with a managed care plan from a private insurer. You can choose from three types of Medicare Advantage plans:

- HMO plan (Health Maintenance Organization)
- PPO plan (Preferred Provider Organization)
- PFFS plan (Private Fee-for-Service)

Medicare Advantage plans may be purchased with or without prescription drug coverage.

A Closer Look at Medicare Supplement Plans

The Basics

Let's look at the first option, a Medicare Supplement Plan. These plans are also sometimes called "Supp Plans" or "Medigap" plans.

Medicare Supplement plans are designed to cover some of the gaps in Medicare Parts A and B. However, Medicare actually defines the kinds of coverage that can be offered in these Supplement plans, and labels them with a letter (A through L). The higher the letter, the more coverage in the Supplement plan.

Some of the richer plans cover 100% of the "gaps" in Medicare Parts A and B. All Medicare Supplement plans provide medical and hospital coverage only. If you want prescription drug coverage you will need to buy a separate Part D Prescription Drug plan.

Most Medicare Supplement plans have no restrictions on which doctor or medical facility you use, as long as the provider accepts Medicare for payment. There are a few Medicare Supplement plans, called Medicare Select, that can have a defined region or network, but these plans are not common. You will continue to use your red, white, and blue Medicare card along with your Supplement plan membership ID card.

How Are Supplement Plans Paid?

You must pay a premium for a Medicare Supplement plan. Supplement plans work hand in hand with Medicare to coordinate coverage. Medicare pays most of your expenses while the Supplement picks up many uncovered Medicare expenses.

Additional Services

Some Medicare Supplement plans may have additional benefits or services beyond Original Medicare. This varies by insurance carrier.

Medicare Supplement plans are labeled A through L. Plan C and Plan F are the most popular. The following is a comparison of plans A, B, C, and F. The cost of the premium for each plan varies by the insurance

company issuing the coverage. Plan A costs the least and Plan F costs the most of the four options shown below.

Covered Benefit	Plan A	Plan B	Plan C	Plan F
Part A Hospital Stay Deductible		✓	✓	✓
Copayment days 61-150	✓	✓	✓	✓
Coverage for an Additional 365 Days in a Hospital	✓	✓	✓	✓
Part B Medical Deductible			✓	✓
Part B Medical Coinsurance	✓	✓	✓	✓
Parts A & B Blood Deductible	✓	✓	✓	✓
Part B Excess Charges				✓
Skilled Nursing Facility coinsurance	✓	✓	✓	✓
Foreign Travel			✓	✓

Medicare Advantage Plans

Medicare Advantage plans are "Part C" of Medicare. They actually replace Original Medicare with what is known as a managed care plan.

The Basics

You must enroll in Original Medicare Parts A and B in order to be enrolled in a Medicare Advantage plan. However, you no longer use your red, white and blue Medicare card; you use your Medicare Advantage membership ID card instead.

Medicare Part C managed care plans (HMOs and PPOs), offer a network of doctors and hospitals that you must use for your medical care. The only exceptions are for an emergency, out-of-area urgent care, or out-of-area kidney dialysis. The type of coverage for out-of-network care varies by the plan's policies. Note: PPO plans provide out-of-network coverage, but often you will pay a higher share of the cost for such care. Out-of-area refers to services delivered outside the plan's geographic service area. Out-of network care refers to services performed by providers

who are not part of the managed care plan's network. Note: If you pick a Medicare Advantage plan, it is important to look for features like coverage for worldwide medical emergency services if you travel.

How Are Medicare Advantage Plans Paid?
Medicare pays private insurance companies to offer Medicare Advantage plans, which is why some plans can have a monthly plan premium of zero dollars. You still need to pay your Part B premium along with the premium for the Medicare Advantage plan (if its premium is more than zero dollars per month).

With a Medicare Advantage plan, you may be responsible for paying deductibles, coinsurance, and copays. Some plans specify a maximum out-of-pocket amount that you can pay per year for hospital and doctor charges. A few typical examples of how such plans work are shown on the next page.

Additional Services
In addition to covering everything provided under Original Medicare, Medicare Advantage plans often offer services not covered by Medicare. Additional services may include annual physicals (covered only once per lifetime under Medicare), routine vision and hearing coverage, and fitness benefits. They can also have additional services that vary by plan and location.

Medicare Advantage plans may include prescription drug coverage. However, you may want to consider a plan without drug coverage if you have prescription drug coverage through a former employer, the Veterans Administration (VA), a state pharmacy assistance program like PACE or PACENET in Pennsylvania, or a federal drug program.

Medicare Advantage Plans and Medicare Part A

How do costs under a typical Medicare Advantage plan compare to costs under Medicare Part A?

Let's look at an example of a typical Medicare Advantage plan with a deductible ranging from $100 to $250 per hospital stay and having a maximum out-of-pocket deductible cost limit that is equal to three stays per year. After you have reached that maximum out-of-pocket cost, you pay nothing for all subsequent covered hospital stays during the course of that year.

Part A	Original Medicare	Typical Medicare Advantage Plan
Hospital Stay Examples:	Under Medicare Part A, the beneficiary pays:	Under typical Medicare Advantage "managed" plan, the beneficiary has a hospital copay of $100-$250 per hospital stay or a maximum of $300-$750 for the calendar year
Beneficiary 1 spends 15 days in the hospital: 3 stays of 5 days each, each within less than 60 days of each other and all within a calendar year.	**$1,068**	**$300** to **$750** depending on plan
Beneficiary 2 spends 95 days in the hospital: all stays within less than 60 days of each other, and all within a calendar year.	**$11,748**	**$300** to **$750** depending on plan

This is quite a difference! Under Original Medicare, Beneficiary 2 owes $11,748 for hospital costs. Under a Medicare Advantage plan, Beneficiary 2 would owe just $300 to $750.

> **Note:**
> Medicare Supplement plans discussed on page 14 would pick up varying levels of this out-of-pocket cost depending on which Medicare Supplement plan a beneficiary chooses.

Medicare Advantage Plans and Medicare Part B

Under Medicare Part B, you pay the first $135 of costs (each year) and then 20% of the balance of the cost of doctor services (that is, of the Medicare-approved amounts). In the example below, if Beneficiary 2 had surgical procedures totaling $10,250 in doctor costs and the Part B deductible had not been paid, that would mean a cost of $2,158 to the beneficiary under Part B. If Beneficiary 1 had a procedure with a physician cost of $5,135 and the Part B deductible had not been paid, that would mean a cost of $1,135 to the beneficiary. Under a typical Medicare Advantage plan, you would face no additional cost for doctor charges (beyond the hospital copays listed on the previous page), unless there is an outpatient copay.

Part B	Original Medicare	Typical Medicare Advantage Plan
Adding Cost of Surgery to Beneficiaries 1 and 2:	Under Medicare Part B, the beneficiary pays:	Under typical Medicare Advantage "managed" plan, the beneficiary pays:
Beneficiary 1 has $5,135 in doctor costs for surgical procedure.	**$1,135** *	**$0**
Beneficiary 2 has $10,250 in doctor costs for surgical procedures.	**$2,158** *	**$0**

> **Note:**
> This coinsurance would be paid for under some Medicare Supplement plans.

* The $1,135 includes the $135 deductible plus 20% of the remaining charges of $5,000 equals $1,000. The $2,158 includes the deductible of $135 plus 20% of the remaining charges of $10,115 equals $2,023.

Note about Special Needs Plans:
Medicare beneficiaries who have a low income or chronic conditions may be eligible for Special Needs plans. To be eligible for a Special Needs plan, you must be enrolled in both Medicaid and Medicare (red, white, and blue card). Special Needs plans for those with chronic conditions do not have low-income requirements but are based on a specific disease category. Contact your Social Security office if either of these circumstances applies.

Private Fee-for-Service Plans (PFFS)

PFFS is a type of Medicare Advantage plan administered by a private company that replaces Original Medicare. A PFFS plan reimburses doctors and hospitals directly based on a fixed schedule of payments. You may not be limited to a specific network of providers. You may be able to go to any eligible doctor or hospital (or other type of medical provider) as long as the provider is willing to accept the PFFS plan's terms and conditions of payment. You may be responsible for deductibles, copays, and coinsurance.

A word of caution: Each provider can decide on a case-by-case basis whether to accept the PFFS plan's terms and conditions of payment. Thus, a doctor could accept it one day, and turn it down the next. Also, you should know that some PFFS plans allow what is called "balance billing." Under such a plan, the doctor or facility can actually bill you for the difference between what the PFFS plan pays and the doctor's or facility's "standard charge" for a given procedure, up to a maximum of 115% of the Medicare allowable payment.

PFFS plans may not include prescription drug coverage. If you opt for a PFFS plan that does not include prescription drug coverage, you'll need to consider enrolling in a prescription drug plan separately.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare Supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept the plan's payment terms and conditions, the doctor or hospital may choose not to provide health care services to you, except in emergencies.

The Basic Difference Between Medicare Supplement and Medicare Advantage Plans

The best way to think about the difference between a Medicare Supplement plan and a Medicare Advantage plan is that the first one supplements the coverage of Original Medicare whereas a Medicare Advantage plan replaces Original Medicare.

To Sum It Up:

Supplement plans can cover up to 100% of the gaps in Medicare. You may use any provider you choose as long as the provider accepts Medicare for payment.

Medicare Advantage HMO and PPO plans, also known as managed care plans, offer a comprehensive package of medical benefits that replace Original Medicare and typically provide extra benefits. They provide assurance that your out-of-pocket medical costs for covered services will be more affordable. Your medical services must be performed by network providers, except for emergencies, out-of-area urgent care, or out-of-area kidney dialysis.

Another type of Medicare Advantage plan is a Private Fee-for-Service Plan (PFFS). A PFFS may or may not have a network, but there are no geographical restrictions as to which providers you can use. However, providers can decide on a case-by-case basis whether to accept the terms and conditions of payment of the PFFS plan.

Quick Reference Chart – Covering the Gaps

	Medicare Supplement Plans	Medicare Advantage HMO	Medicare Advantage PPO	Medicare Advantage Private Fee-for-Service Plan (PFFS)
Replaces Original Medicare	No	Yes	Yes	Yes
Network provider restrictions	No	Yes	Yes, but allows for out of network at higher cost-sharing levels	No
Option to include Prescription Drug plan / coverage	No, separate plan	Yes	Yes	Varies by plan
Includes "extra benefits"	Varies by plan	Yes	Yes	Varies by plan
Has copay / coinsurance or deductible	Depends on plan selected	Yes	Yes	Yes

Medicare Part D — Prescription Drug Plans

Medicare Part D is insurance coverage for prescription drugs. Part D coverage is provided by private companies, and a monthly plan premium is charged for coverage. Medicare Part D plan benefits are based on a schedule of deductibles, copays, and coinsurance. There is also a coverage gap in the standard Medicare Part D plan. Some insurance companies may cover prescription drugs in the "coverage gap." We'll talk more about this later in this section.

Rules Surrounding Medicare Part D Coverage

To get coverage, you have to enroll in a Medicare Part D plan. Premiums for calender year 2009 typically range from $15 to $100 per month depending on the plan you choose.

You have to be enrolled in Medicare Part A or B in order to enroll in Medicare Part D.

Note: If you do not enroll in Medicare Part D during your Initial Coverage Election Period (see page 29), you may have to pay a penalty if you enroll later.

The Standard Prescription Drug Plan

Medicare defines a standard prescription drug plan, which is used as the baseline for all private insurance company plans. Private companies offering Medicare Part D plans must equal or exceed the standard prescription drug benefits as defined by Medicare. The coverage in the standard plan includes several stages, based on the amount of covered drugs you buy on an annual basis.

In 2009, the standard plan begins with an annual deductible of $295. So you must pay the first $295 in covered prescription drugs. (Please note that the annual deductible is subject to change each enrollment year.)

If you purchase drugs with a total cost between $295 and $2,700 you pay 25% of the cost of these drugs. That would amount to $601.25 plus the $295 deductible, which equals $896.25.

Most private insurance plans offer a comparable Part D plan that meets the CMS minimum standard plan requirements by using copays instead of deductibles and coinsurance.

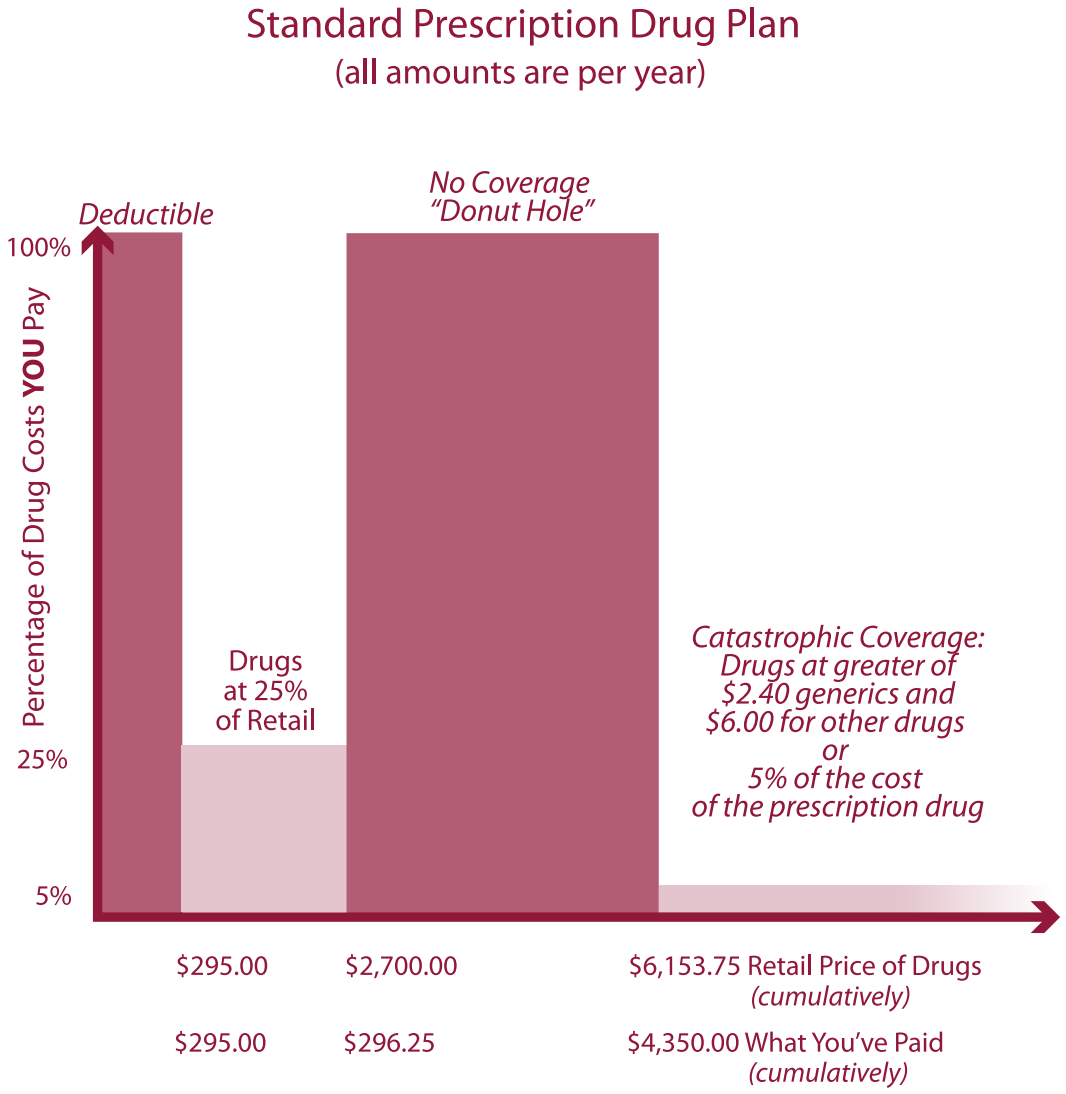
The Donut Hole

When the total amount spent on your drugs by both you and your plan equals $2,700, you enter the coverage gap, or "donut hole."

While in the donut hole, you pay 100% of the cost of your prescription drugs until you've spent a total of $4,350 out of your pocket. Once you've spent that much, you get out of the donut hole.

Next you enter the catastrophic coverage stage, where you pay the greater of 5% of the cost of prescription drugs, or $2.40 for generics and $6.00 for other drugs.

Your $295 deductible starts over at the beginning of each calendar year. The deductible amounts may change annually. The amounts above are for calender 2009.



How Good a Deal Is the "Standard Plan"?

Medicare Part D is a good deal indeed if you get into the catastrophic stage of prescription drug usage. But what if you don't? Remember, prescription drug plans have a monthly premium of approximately $15 to $100 per month. That adds at least $180 per year to the cost of your prescription drugs.

Prescription Drug Plan Options

The variety of private plan options is large, especially since each plan offers a particular formulary listing the drugs that are covered and the levels of copay. A formulary usually includes the following categories, typical copays for each category are shown:

Type of Drug:	**Typical Copays:**
Generic Drug	$ 5
Preferred Brand Drug	$25
Non-preferred Brand Drug	$50
Specialty Drug	25% to 33%

Each private company offering a Medicare Part D plan negotiates prices with drug companies. Some get better prices on one brand of drug versus another — thus the "preferred" designation for some brand drugs. About one-third of Part D plans offer some coverage through the donut hole, typically for generic drugs.

Remember, all Part D plans are also subject to monthly plan premium payments, which are an additional cost you must consider.

Part D Typical Prescription Drug Plan Copays

Initial Coverage
$0 - $2,700

You pay a copayment of:

- $5 for a 31-day supply of a generic drug
- $32 for a 31-day supply of a preferred brand drug
- $64 for a 31-day supply of a non-preferred brand drug
- 33% for specialty drugs

Coverage Gap

You pay:
100%
beginning at
$2,701

Catastrophic Coverage:

After your out-of-pocket drug costs reach $4,300 for the year, you pay a copayment of:

- $2.40 for a 31-day supply of a generic or brand formulary drug
- $6.00 for a 31-day supply for all other drugs; or 5%, whichever is greater

> **Note:**
> Most Part D benefit plans offer copayments rather than the annual deductible and coinsurance of the standard CMS Part D plan.

Let's take a look at a standard prescription drug plan, using typical copays and coinsurance for specialty drugs.

Special Assistance for Medicare Part D

Special assistance programs are available to low-income individuals. These programs can pay for all or a portion of your Medicare Part D premiums. Please see the Medicare website www.Medicare.gov, click on "Prescription Drug Plan," and then click on the box for "Extra Help" to learn about this. Or, contact your local Social Security Administration Office (see page 35) or state Medicaid office.

Pennsylvania offers a State Pharmaceutical Assistance Program (SPAP) called PACE/PACENET that will pay for part of your prescription drug costs and cover prescriptions in conjunction with a Medicare Part D plan. To be eligible for PACE or PACENET, you must be 65 years of age or older, you must be a Pennsylvania resident for at least 90 days prior to the date of application, and you cannot be enrolled in the Department of Public Welfare's Medicaid prescription benefit. See page 36 for contact information.

To Sum It Up:

Supplement plans do not include Medicare Part D Prescription Drug coverage. If you choose a Supplement plan, you must purchase a drug plan separately. Many Medicare Advantage Plans include Part D prescription drug coverage.

Enrollment in Medicare Part D is voluntary, but there may be penalties and higher premiums if you do not enroll when you are first eligible!

Medicare Part D has a coverage gap. If your drug expenses are high, you may want to look for a plan that at least covers generics through the coverage gap or "donut hole."

Enhanced prescription drug plans typically have higher monthly premiums than standard plans, so compare carefully.

Medicare has an online tool available to help you compare plans. It's on the Plan Finder page of www.mymedicare.gov or www.Medicare.gov (or call 1-800-Medicare). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Many companies offering plans also have online tools on their websites.

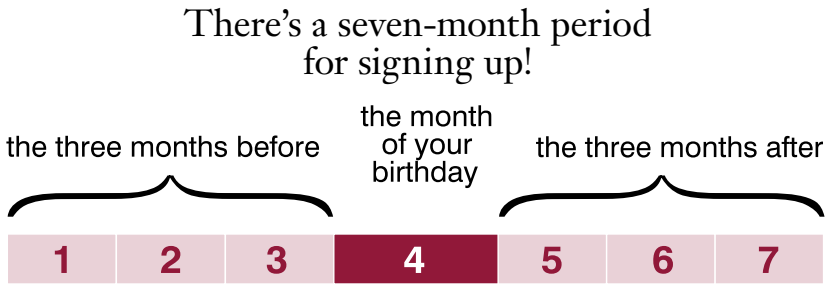
More Things You Should Know

How Enrollment Works

And How and When You Can Change Plans

Initial Coverage Election Period

You have seven months (starting three months before the month of your 65th birthday) to enroll in Medicare. This is called your Initial Coverage Election Period.



To enroll, you can contact Social Security, Monday through Friday, 7 a.m. to 7 p.m. at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778.

Social Security will ask you to set up an interview with a claims representative. The representative may be able to schedule a phone interview immediately, or you can schedule a specific appointment at a Social Security office near you for an in-office interview. Note: You will need to provide proof of age and citizenship, such as a birth certificate. You may also be asked for documents that could affect your coverage or that of your spouse (such as separation-from-military papers or divorce papers).

You can enroll in Medicare Part D Prescription Drug coverage during the Initial Coverage Election Period. You cannot do this though the Social Security office; you must enroll on your own through a private company. (Note: You could incur a premium penalty if you enroll in Part D after the Initial Coverage Election Period. See Annual Election Period on the following page.)

When you are enrolled in Medicare Parts A and B, you may also enroll in a Medicare Supplement plan (Medigap) or a Medicare Advantage plan.

> **Note:**
> If you are already getting Social Security retirement or disability benefits when you reach your 65th birthday, you will typically be contacted and automatically enrolled in "Original Medicare" (Parts A and B).

The General Enrollment Period for Medicare Part B (does not apply to Medicare Supplement plans)

The General Enrollment Period for Medicare Part B is from January 1 through March 31 of each year. If you do not enroll in Medicare Part B during your Initial Coverage Election Period, you may do so during this General Enrollment Period. Note: Your monthly premium can increase 10% for each 12-month period you were eligible for but did not enroll in Part B, and you will have to pay this penalty as long as you have Medicare Part B. If you enroll during this General Enrollment Period, your coverage begins July 1.

> **Exceptions to the Penalty Above:**
> If you are covered under a group health plan (either from your current employment or your spouse's), you may delay enrolling in Medicare Part B until that coverage ends, without penalty. (However, COBRA coverage following separation from employment doesn't count.) There are other special exceptions for people receiving Social Security disability payments — consult the literature from Social Security for details.

The Annual Election Period (does not apply to Medicare Supplement plans)

The Annual Election Period runs from November 15 to December 31 each year. During this time, you can change Medicare Advantage plans, you can change insurance companies, or you can even drop out of Medicare Advantage plans altogether. During this period, you can

also enroll in Medicare Part D if you did not do so during your initial enrollment period. Note: There may be a penalty in your monthly premium for having waited to enroll. This penalty will be monthly for as long as you have Medicare Part D.

The Open Enrollment Period
(does not apply to Medicare Supplement Plans)

The Open Enrollment Period is the three months following the Annual Election Period — January 1 to March 31 — when you are allowed to fine-tune your coverage. You can change to a new plan with a new company as long as it is similar to the plan you selected in the Annual Election Period. (See the Medicare literature for the details on this.)

Special Election Periods
(does not apply to Medicare Supplement plans)

Special Election Periods are periods outside of the usual Annual Election Period or Open Enrollment Period when an individual may elect a plan or change his or her current plan election. Special Election Periods are available when you move outside the plan's service area, lose coverage from a former employer group or union, or have Medical Assistance coverage and have recently been approved for "extra help."

Initial Coverage Election period	**Annual Election Period** *	**Open Enrollment Period** * (For Part D and Medicare Advantage plans) **General Enrollment Period** * (For Part B)
7 months around your 65th birthday	November 15 – December 31	January 1 – March 31
When you initially enroll.	When you can change/delete just about anything.	Fine tuning of Medicare Advantage plans and Part D. Second chance to enroll in Part B

* Does not apply to Medicare Supplement plans.

What Original Medicare Doesn't Cover

Medicare provides little or no coverage for the following services that may be important to Medicare beneficiaries:

- Dental care — virtually no coverage for dental care and dentures (with a few exceptions)
- Vision care — no coverage for routine exams or eyeglasses (except after cataract surgery)
- Hearing care – no coverage for hearing aids (or for exams for fitting a hearing aid)
- Fitness programs – no coverage
- Annual physical – no coverage except for the first six months that you have Part B

See the "Medicare & You" booklet for the complete list of services not covered by Original Medicare.

> **Note:**
> Many Medicare Advantage plans provide some coverage for all of the above.

Good Questions to Ask When Making Your Choice of Medicare Advantage or Medicare Supplement Plans

1. How much do the plans cost (premiums) and what benefits do you get for those costs? What is your annual out-of-pocket cost if you are hospitalized or have an illness?

2. What sort of wellness or preventive benefits are available under the plan? This could include preventive screenings such as mammograms, cholesterol screening, and annual physical exams, to name a few.

3. Are there any extra or special benefits? These could include:
   - Emergency coverage if you are traveling internationally
   - Routine vision care benefits
   - Hearing aid benefits
   - Dental coverage
   - Fitness club membership
   - Nurse advice line

4. If researching a managed care plan:
   - What is the network of doctors and hospitals?
   - Is there a network of providers if you travel, or at least emergency travel assistance?
   - Do you need a referral from your primary care provider to see a specialist (HMO)?
   - What is the difference in benefit levels in and out of network (PPO)?

5. If researching a Medicare Supplement plan (Supp Plan or Medigap):
   - What level of coverage do you want (Plan A provides the least, Plan F the most)?
   - Are there additional benefits, like vision care, hearing aid, or dental coverage?

These are a few things to consider when making a choice about your Medicare health coverage.

Resources

How You Can Get Additional Information

***Medicare*:** A small booklet typically mailed out by Social Security before your 65th birthday.

***Medicare & You*:** A big booklet mailed out each year to Medicare enrollees by Medicare.

Medicare website: www.medicare.gov

Medicare phone numbers:

To get general information about Medicare or Part D benefits, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week.
TTY/TDD users, call 1-877-486-2048.

Social Security website: www.ssa.gov

Social Security phone number for Medicare:

To get general information on Social Security and Medicare, you can call 1-800-772-1213, 7 a.m. to 7 p.m., Monday – Friday.
TTY/TDD users, call 1-800-325-0778.

Pennsylvania Resources

Department of Aging: Offers APPRISE, the state health insurance assistance program. Through this free program, trained APPRISE counselors are available to help seniors 60 or older understand Medicare and Medicaid eligibility and benefits. APPRISE counselors also help seniors compare Medicare Supplement insurance plans; Medicare managed care plans, long-term care insurance, and other health insurance and public benefit programs.

The Pennsylvania Department of Aging has a new website (www.aging.state.pa.us) specifically designed to help older Pennsylvanians. This site includes links to local services such as your county's Area Agency on Aging ("Your Local Resources" link on the left) and contact information for APPRISE counselors ("Health and Wellness" link on the left). Call 1-800-783-7067.

Pennsylvania Health Law Project (PHLP): Provides information for dual-eligible (Medicaid and Medicare) and other low-income people who qualify for federal subsidies to enroll in Part D. Help is available from the Pennsylvania Health Law Project by calling 1-800-274-3258. TTY/TDD users, call 1-866-236-6310. You can also visit its website at www.phlp.org or e-mail at staff@phlp.org.

PACE/PACENET: For low-income individuals who need help paying for prescriptions, PACE/PACNET will coordinate with their Medicare Part D and Retiree Prescription coverages. Call 1-800-225-7223. TTY/TDD users call 1-800-222-9004. To enroll on line: https://pacecares @ fhsc.com

Ohio Resources

Ohio Senior Health Insurance Information Program (OSHIIP): Educates consumers about Medicare through its speakers bureau, hotline experts, and trained volunteers. You may contact OSHIIP at its toll-free hotline, 1-800-868-1578, or e-mail oshipmail@ins.state.oh.us.

Ohio Department of Aging: Has a website, www.goldenbuckeye.com, designed to help older beneficiaries. You can also call 1-800-266-4346. TTY/TDD users,
call 614-466-6191.

West Virginia Resources

West Virginia Bureau of Senior Services: The West Virginia Bureau of Senior Services is a cabinet-level agency within state government that acts as the lead entity for programs serving older West Virginians. You can call 304-558-3317 or visit the website at www.seniorservices.gov.

Glossary

Balance Billing	Under some Private Fee-for-Service plans (see below), providers can "balance bill" you; that is, bill you an additional amount over and above the PFFS plan's reimbursement up to 115% of that amount. Also applies to Original Medicare if a doctor does not accept assignment.
Beneficiary	Person covered by insurance.
Coinsurance	A percentage of the cost you must pay for a medical service after you have paid the deductible (see below), with the medical insurance paying the balance.
Copay	An amount you must pay on a per-service basis for things like prescription drugs or doctor visits.
Deductible	The amount you must pay first for medical services before insurance coverage begins to pay.
Medicare Supplement Insurance	Private insurance that covers some or all of the gaps in Medicare coverage. Does not include any prescription drug coverage.
Original Medicare	Parts A and B of Medicare are called "Original Medicare." Original Medicare is a fee-for-service health plan; that is, you can go to any provider who accepts Medicare fees or participates in the Medicare program. You pay any deductibles and coinsurance as required (the "gaps").
Out-of-Pocket Maximum	An annual limit to the amount you have to pay in copays, deductibles, and coinsurance for covered medical services under some private Supplemental or Medicare Advantage insurance.

Part A	The part of Medicare that is insurance for medical facility costs.
Part B	The part of Medicare that is insurance for doctor's services and other medical services not covered in Medicare Part A.
Part C	The name given to Medicare Advantage programs, the private company-operated managed care plans that replace Medicare Parts A and B.
Part D	The name given to the prescription drug benefits covered by Medicare.
Premium	The cost to you of medical or prescription drug insurance coverage, typically paid on a monthly basis.
Private Fee-for-Service (PFFS)	A type of Medicare Advantage plan operated by a private company. In a Private Fee-for-Service plan, you may be able to go to any provider that accepts the plan's terms and conditions of payment for the services. Note: There can be balance billing in such cases (see page 37).
Provider	Any person or entity that provides for covered services to the Beneficiary, such as doctors, hospitals, home health agencies, and pharmacies.
Supp Plan	Short for Supplemental plan, another name for Medicare Supplement Insurance (see page 37).

This pamphlet was provided to you by
UPMC *for Life*, the
UPMC Health Plan Medicare Advantage Program.

For more information contact us at the telephone number below.

Hours of Operation: 8 a.m. to 8 p.m., seven days a week.*

Telephone Number: 1-866-786-7035
TTY/TDD Telephone Number: 1-800-361-2629

* From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

UPMC *for Life*

UPMC Health Plan Medicare Program

To find out if UPMC *for Life*
is right for you, call toll-free
1-877-381-3765

TTY/TDD users should call
1-800-361-2629

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on weekends and holidays. Please
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UPMC Health Plan
Where you belong.

One Chatham Center
112 Washington Place
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www.upmchealthplan.com/medicare

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